WRMA
Walter R. McDonald & Associates, Inc.

FINDINGS FROM THE

COUNTYWIDE FOCUS GROUPS

CONDUCTED FOR THE MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN
IN LOS ANGELES COUNTY

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Prepared for:
The Los Angeles County Department of Mental Health

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I. Introduction

The Los Angeles County Department of Mental Health (LACDMH) is engaged in an intensive, inclusive, and multi-faceted approach to developing the County's Prevention and Early Intervention (PEI) Plan to be funded through the Mental Health Services Act (MHSA) enacted by California voters in 2004.

The focus for developing the PEI Plan is at the Service Area level, utilizing informational meetings, key stakeholder interviews, focus groups, and community forums in each of the eight geographic areas of Los Angeles County. Because each Service Area has distinct and varying populations, geography, and resources, it is critical for PEI services to be specific and responsive to regional and community-based needs.

The California Department of Mental Health (CDMH) has defined *mental health prevention* as reducing risk factors or stressors, building protective factors and skills, and increasing support to allow individuals to function well in challenging circumstances. Whereas, *mental health early intervention* involves a short duration (usually less than one year) and relatively low-intensity intervention to measurably improve a mental health problem or concern early in its manifestation and avoid the need for more extensive mental health treatment or services later.

In addition, CDMH has targeted five community mental health needs, six priority populations, and six statewide efforts for the PEI Program, and has identified seven sectors that counties must partner with to develop their PEI Plan.

This report presents the findings from the Focus Groups with countywide representation. Each service area will receive a report of the findings specific to the focus groups selected to speak on its behalf. In addition, a comprehensive final report will be produced presenting aggregate findings across all of the focus groups conducted in Los Angeles County.

II. Methodology

Participants

Each focus group was comprised of no more than 10 participants. Participants were drawn from existing groups/agencies for the purpose of participating in a discussion about the mental health service needs, barriers, and strategies in their respective communities.

- As with the Key Individual Interviews, the focus groups were selected based on Service Area and/or countywide representation and the categories of MHSA age group, sector, priority population, and key community mental health needs for PEI. Utilizing recommendations made from LACDMH District Chiefs, Service Area Advisory Committee (SAAC) members, and other stakeholders throughout the county familiar with the categories, LACDMH selected focus groups that qualified in at least two PEI categories.

- LACDMH identified a focus group coordinator from each community group/agency selected. The focus group coordinator sought participation in the focus group from among the agency's membership. Focus group coordinators were asked to identify and invite a diverse group of participants who could speak about service needs, barriers, and recommended strategies for their Service Area or, for this particular report, from a countywide perspective.

Participating Agencies

A total of 159 individuals from the following 17 countywide agencies/organizations were asked to participate in their respective focus group:

1. Asian Pacific Policy and Planning Consortium (A3PCON);
2. California State University, Long Beach - Suicide Prevention and Intervention Team;
3. Community Clinic Association of Los Angeles County;
4. Greater Los Angeles Agency on Deafness, Inc. (GLAD);
5. ICARE Network (prenatal to five focus);
6. Los Angeles Coalition of School Health Centers;
7. Los Angeles Community College District (LACCD);
8. Los Angeles County Commission for Children and Families;
9. Los Angeles County Department of Children and Family Services - Transitional Housing Program;
10. Los Angeles County Department of Mental Health - Children's Outpatient Programs;
11. Los Angeles County Department of Mental Health - Psychiatric Mobile Response Team (PMRT);
12. Los Angeles County Mental Health Commission;
13. Los Angeles County Older Adult System of Care (OASOC);
14. Los Angeles County Probation Department - Transition-age Youth (TAY) Residents of Dorothy Kirby Center;
15. National Alliance on Mental Illness (NAMI);
16. United American Indian Involvement (UAII); and,
17. United States Veterans, Inc. - Double Trudgers.

- The 17 participating agencies from which the focus groups were drawn have been in existence between less than 1 year and 50 years. Among the 17 agencies, 13 have between 7 and 300 or more members. One agency represents over 35 organizations and another represents over 1,500 members when all its affiliates are included in the count. Two focus groups did not report their total number of members.

- Across the 17 participating agencies, members represent individuals ages zero to over 60. One agency represents children zero to five exclusively and another agency represents children zero to five and transition-age youth. Of the other 14 agencies, five represent transition-age youth, adults and older adults; three represent adults and older adults only, and another three agencies represent adults only. Two agencies exclusively represent transition-age youth. Finally, one agency represents adults only and the last agency represents transition-age youth and adults.

- With respect to the ethnic composition of the 17 agencies, all the ethnicities listed on the form are represented by at least one agency.[1] The most highly represented ethnicities are: African American (14 agencies), Latino/Hispanic (13 agencies), and Caucasian (13 agencies). All other ethnicities are represented by between one and nine agencies.

- Finally, the following community sectors are represented across the 17 agencies: Community Family Resource Centers, Education, Employment, Health, Individuals with Serious Mental Illness, Law Enforcement, Social Services, and Underserved Communities.

[1] Ethnicities represented: African American; American Indian; Asian/Pacific Islander: Cambodian, Chinese, Filipino, Japanese, Korean, Samoan; Latino/Hispanic, Caucasian, Eastern European/Middle Eastern: Armenian, Farsi, Russian, Other; and, Other.

Procedures

Each focus group coordinator worked closely with a member of the contracted consulting team to arrange focus group dates, times, and locations.

The focus groups were conducted at the organizations or agencies representing the focus group participants or other community-based locations. The focus groups were audio recorded and took about two hours to complete. Nine key questions, some of which contained sub-questions, were posed to focus group participants. The questions were designed to produce information needed to inform the PEI planning process. A copy of the Focus Group Guide can be found in **Appendix A**.

Facilitators representing LACDMH at the focus groups as a neutral third party included a team of three staff members from Walter R. McDonald & Associates, Inc. (WRMA) and their subcontractors, EvalCorp Research & Consulting, Inc., and Laura Valles and Associates, LLC. One team member facilitated the focus group, another observed and documented notes, and a third recorded participants' responses on flip charts, which participants could refer to throughout the focus group.

Focus group documentation included: a Focus Group Profile, a Focus Group Participant Profile, a signed Consent Form indicating that the focus group would be audio recorded, the observer's electronic notes, the paraphrased responses from participants, an audio recording of the focus group, and a transcript of the focus group developed from the audio recording. A report was written by the focus group team observer, summarizing the group's responses to the questions. Information from each focus group was coded so that the data could be analyzed and presented in summary format.

III. Knowledge of the PEI Planning Process

Participant Participation in the PEI Planning Process (Q1)

The first question(s) that focus group participants were asked to answer was "Have you or your group taken part in the Los Angeles County Department of Mental Health's PEI planning process? And, if so, how?" Among 159 participants, 73 reported having some experience with or participation in the PEI planning process. Although not all 73 reported how they had participated in the process, the following list provides a countywide representation of how focus group participants had been involved in the process. Of the 17 focus groups, four included participants who had no prior knowledge of the PEI process.

Reported Knowledge of and Participation in the PEI Planning Process

Type of Participation	Number of Reported Participants (n=61)*
SAAC Meeting Attendance	17
MHSA Stakeholder Delegates and Meeting Attendance	10
Local Committee Chair, Co-Chair, Members	8
Service Area Planning Meetings	4
LA County Department of Mental Health Meetings	3
Mental Health Services Oversight and Accountability Commission	3
System Leadership Team Member	1
Other Informational Meetings: • Advocacy Group Meetings • California Primary Care Association • Childcare Roundtable • Community Clinic Association of Los Angeles County • Conference Calls and Listservs • Department of Children and Family Services • Los Angeles Unified School District • Mental Health Group • Older Adult System of Care • Organizational advisory committee meetings. • WET Bureau	15

*Not all of the 73 participants who reported knowledge of or participation in the PEI planning process specified the nature of their knowledge or participation.

IV. Service Area and Priority Population Representation

Service Area (Q2)

When focus group participants were asked which service area they represent, the specific number of individuals representing each service area was collected from all but three focus groups. Among the participants in 14 of 17 focus groups, 63 indicated that they represent populations countywide. One participant represents Service Area 1; eight represent Service Area 2; five represent Service Area 3; twenty-two represent Service Area 4; six represent Service Area 5; twenty-seven represent Service Area 6; four represent Service Area 7; and, twenty-eight represent Service Area 8. One participant stated that he/she serves individuals statewide as well as countywide, and another indicated that she serves individuals and populations within the boundaries of LAUSD.

Priority Populations (Q2a)

The CDMH has identified the following six priority populations for PEI services: 1) Underserved cultural populations; 2) Individuals experiencing the onset of serious psychiatric illness; 3) Children and youth in stressed families; 4) Trauma-exposed individuals; 5) Children at risk for school failure; and, 6) Children and youth at risk of or experiencing juvenile justice involvement. Focus group participants were asked to select the priority populations they represent. As shown in **Table 1**, the majority of participants considered all the priority populations important with only a seven percentage point spread between the top two priorities and the last priority. Children and youth in stressed families and Trauma-exposed individuals were tied for the top priority, representing 76 percent of the participants each. These two top priorities were closely followed by Underserved cultural populations and Individuals experiencing the onset of serious psychiatric illness, representing 75 and 74 percent of participants, respectively. Children and youth at-risk of or experiencing juvenile justice involvement and Children at-risk for school failure were represented by slightly fewer participants (70% and 69 %, respectively). A breakdown by focus group is provided in **Table 1A** in **Appendix B**.

Table 1: PEI Priority Populations

PEI Priority Populations	Number of Participants	Percent of Participants (n=159)
Children/youth in stressed families	121	76%
Trauma-exposed individuals	121	76%
Underserved cultural populations	120	75%
Individuals experiencing the onset of serious psychiatric illness	118	74%
Children/youth at-risk of or experiencing juvenile justice involvement	112	70%
Children at-risk for school failure	110	69%

V. Community Mental Health Needs and Impacts

Mental Health Needs in the Community (Q3 and Q3a)

Each focus group participant identified the mental health needs in his/her community based on five MHSA categories: 1) Disparities in access to mental health services; 2) Psycho-social impact of trauma; 3) At-risk children, youth, and young adult populations; 4) Stigma and discrimination; and, 5) Suicide risk.

Slightly more than 8 in 10 participants identified Disparities in access to mental health services (82%) as a top mental health need in their communities. Following Disparities in access to mental health services, the remaining mental health needs were identified by between 74 and 77 percent of focus group participants as the 2nd through 5th priority service areas: Suicide risk (77%), At-risk children, youth, and young adult populations (77%), Psycho-social impact of trauma (76%), and Stigma and discrimination (74%). A breakdown by focus group is provided in **Table 2A** in **Appendix B**.

Table 2: PEI Mental Health Needs

PEI Mental Health Need	Number of Participants	Percent of Participants (n=159)
Disparities in access to mental health services	130	82%
Suicide risk	123	77%
At-risk children, youth, and young adult populations	122	77%
Psycho-social impact of trauma	121	76%
Stigma and discrimination	117	74%

"We see between 12 and 25 suicidal individuals a year and most of them go back to school. We put them back together and get them back on track. And we could do so much more in terms of prevention if we could have the funding."

When asked to identify the top three mental health needs from among the list of five determined by CDMH, 12 focus groups elected Disparities in access to mental health services as the number one priority. Disparities in access to mental health services was followed by At-risk children, youth, and young adult populations, which was selected by 11 of the focus groups. Psycho-social impact of trauma emerged as a third priority. Two of the 17 focus groups elected not to prioritize the mental health needs because the participants felt all the needs should be considered priorities for mental health services. A breakdown by focus group is provided in **Table 3A** in **Appendix B**.

Table 3: Priority PEI Mental Health Needs

Priority PEI Mental Health Needs	Number of Groups (n=15)*	Priority
Disparities in access to mental health services	12	1
At-risk children, youth, and young adult populations	11	2
Psycho-social impact of trauma	8	3

*Two focus groups felt that all the mental health needs were important and interrelated, and elected not to prioritize.

"We don't have enough of any of those services. So, I feel I would really have to prioritize them all."

Impact of the Mental Health Needs on the Community (Q4)

As presented in **Table 4**, focus group participants reflected upon and relayed the negative impact that the unmet mental health needs discussed in the previous section have had on their communities. The five most highly-mentioned impacts concerned: 1) access to mental health services; 2) the increasing number of mental health issues among community members; 3) the pervasiveness of community and family violence and abuse; 4) the social and economic conditions under which community members live; and, 5) the declining quality of services received. Participants also discussed the sense of hopelessness that is arising as a result of broken families and degraded community infrastructures, the increasing numbers of exacerbated mental health care cases and, the lack of knowledge about mental health, poor academic outcomes among children and youth, among a host of other impacts listed in **Table 4**.

"There's a very general lack of understanding about mental illness. In older adults, it is often perceived to be a normal part of aging. So, that those older adults don't see that it's a problem and they just think it's part of getting old."

With respect to accessing mental health services, focus group participants discussed how specific populations are being affected by stigma and discrimination. Some participants reported that older adults are experiencing age-related stigma from care providers who fail to identify and recommend appropriate services for them. Others reported that veterans and stressed families experience stigma due to their responses to psychological trauma. In addition, one focus group noted that children with behavioral and emotional issues are stigmatized because of their behavior, and then further mistreated by family, peers, police, and the community.

"… because there are no interpreters, there are no services, and there's no counseling for them and so you can't get them placed [domestic violence victims]. So they're stuck in their relationship or whatever or they're killed or they're hurt because they have no access to services."

While stigma and discrimination are impacting communities, the lack of available services is also leaving consumers more vulnerable to exacerbated mental health issues and negative outcomes. Participants discussed the lack of intervention services for older adults; pregnant mothers without access to prenatal care who end up vulnerable to premature deliveries; college students whose only source of mental health support is the Disabled Student Programs and Services or the DMH Psychiatric Emergency Team; the deaf and/or blind battered women who end up more seriously injured or worse because there are no domestic violence shelters to accommodate their needs; and the limited number of patient beds in hospitals leaving some people without needed assistance.

Further exacerbating this situation is the lack of service providers who employ multi-lingual, multi-cultural staff, leaving consumers to face the challenges of navigating the system and engaging in services alone; oftentimes, these challenges become too insurmountable and consumers give up without having their needs met. The Asian, Latino, American Indian, and deaf and blind communities were specific cultural populations mentioned by focus group participants as having experienced such challenges.

Inability to access services due to cost and eligibility criteria is also affecting the mental health of communities. Lack of insurance, inability to pay, strict income guidelines, paperwork and billing requirements, and limitations with Medi-Cal, Medicare, and insurance policies, all contribute to a growing proportion of community members with mental health needs that have not been met. Lack of transportation and isolation also contribute to the growing proportion of unmet needs -- as do the delays individuals experience attempting to access services.

"If people don't have the services or are wait-listed, then what happens with no access to beds? There just aren't any. I have kids in crisis with no where to go. We've had to put safety plans in homes. We prioritize who is most needy … now 1 out of 10 kids is a priority! Especially for early intervention. "

The second highest-mentioned community impact was the increasing number of mental health issues surfacing in communities. The mental health issues discussed in the focus groups revolved around the following three: 1) substance abuse; 2) depression and suicide risk; and, 3) trauma, PTSD, and anxiety. With respect to substance abuse, focus group participants have noticed an increase in the number of older adults and youth engaging in substance abuse. Participants commented that youth use drugs and alcohol to medicate themselves from the unpleasant circumstances and conditions surrounding them. Others noted that people experiencing a mental illness often feel isolated and then turn to drugs and alcohol for solace, which in turn leads to depression and sometimes suicide. Depression and suicide were also a concern, and participants pointed out that depression and suicide

"A lot of people are starting to resort to drugs because they feel that they ain't gonna get the help that is needed, so they're just looking for any way to make themselves feel better. And most will find it in drugs and end up overdosing or just getting into jails or institutions. ."

are much higher among those with a mental illness. In addition to those with mental health issues, populations considered to be at risk of depression and suicide were young mothers and youth.

Focus group participants also talked about multiple traumas (e.g., physical and emotional) that have been reported among children with complex mental health needs in adoption programs and those witnessing trauma in their communities. Trauma and anxiety are also experienced among older adults, specifically those who have children with physical or mental health needs.

"Some children are abused in foster placement by other children and re-abused by foster parents."

Often related and coincident with the rise of mental health issues are the instances of domestic violence among children and older adults, violence in schools, gangs, and criminal activity. Participants noted how community and family violence, the third most highly-mentioned community impact, raises stress levels and reduces coping skills, which further feed the violence and abuse, creating a vicious cycle that is psychologically and emotionally detrimental to individuals and the community at large. Contributing to these conditions is the decomposition of the family and overall decay of the community. Focus group participants pointed out that single family homes, dual-worker homes, and families in which one member has been incarcerated or deported feel trapped in their environments and are unable to effectively parent their children or relate as a family. As a result, they become stuck and lose hope for the future.

The breakdown of the community and family structure in conjunction with the insidious nature of community and family violence contribute to the social and economic conditions of the communities represented by the focus groups. Focus group participants acknowledge that the rising mental health needs, stigma, suicides, and the "corruption of the social environment" incite the poverty, unemployment, and homeless that is occurring in communities, and vice versa.

"Families caring for someone with a mental illness encounter great financial difficulties, which leads to poverty."

With respect to service quality, the fifth most highly-mentioned community impact focus groups underscored was the decrease in the level of care, the increase in the number of consumers who have been misdiagnosed, particularly children with complex issues, and the decline in the number of people whose mental health care needs have been met adequately. One focus group highlighted specific ways in which service quality is declining and/or inadequate: services are not family-centered; services are fragmented; social emotional milestones are not recognized; referrals are not monitored; and there is a lack of service continuity among providers. Others discussed the lack of hospital placements and lack of sensitive and trained staff as signaling the decrease in quality care. In one case, focus group participants pointed out that treatment services may have increased but the effectiveness of the services provided has decreased due to a lack of trained staff. This focus group indicated that this was particularly true for children with more serious disorders such as Asperger's Syndrome and Autism.

Attention was also given to the consequences of unaddressed mental health issues. Focus group participants indicated that consumers experience greater mental health problems and hospitalizations due to inability to access services, long wait lists, lack of early intervention, and poor front- and back-end care. One focus group pointed out that a large percentage of the 70,000 to 80,000 homeless in Los Angeles County are people who suffer from poor mental health that has gone either undiagnosed or untreated. Another focus group also indicated that as the lack of access to mental health services leads

to higher and higher numbers of acute situations with patients, the impact on health and mental health care costs will be significant and likely lead to further hardships on communities.

"I see a big need for parent education, specifically around how to deal with your child's emotional issues. Because so many of the parents that we see are from other cultures -- they are dealing with their child's emotional issues the way that their culture does back in their homeland. It just doesn't work.'"

From another perspective, the lack of knowledge and awareness among community members about mental health also plays a role in the number of undiagnosed and unmet mental health needs that are found across Los Angeles County. Focus group participants talked about the general lack of understanding of mental health issues not only by community members, but also by physicians. Among community members, focus group participants were most concerned about parents' lack of understanding of what "at-risk" really means and how to raise emotionally healthy children. As one focus group emphasized, "A lack of parenting skills leads to emotional issues in children."

However, it should be noted that discussions mentioned the idea that parents and caregivers do not always understand that family stressors also can affect a child's development, exacerbate existing atypical behavior, and place additional stress on the child and parents. Participants stated that family stressors also are high among parents and children from other cultures who are struggling with acculturation and assimilation. As one focus group pointed out, the lack of success individuals have with daily life issues often creates a domino effect, negatively impacting other areas of their lives.

"There's a vicious cycle that occurs with the lack of good parenting information that then creates stress in the children who are at risk when they first begin in the school setting, whether it's preschool or kindergarten."

The rise in inappropriate social-emotional behaviors among children, not necessarily due to lack of parenting skills, was also mentioned by focus group participants as having an impact on the community. Participants indicated that children and youth are acting out because they do not have the support they need, that children in child care and child development programs are being expelled for atypical behavior, and at the same time, are experiencing the stigma associated with their behavior. According to focus group participants, the result is one of two extremes: children become combative or withdrawn, and neither parents nor teachers are well-equipped to address and handle the child's needs effectively.

Evidence of poor academic outcomes is also emerging on a wider scale at the high school and college levels. Focus groups mentioned decreases in retention rates, uncompleted homework assignments, and general underperformance among those youth with unaddressed and/or emerging mental health issues. One of the focus groups representing college students indicated that the campuses are seeing more and more college students with unaddressed mental health issues who exhibit anxiety, frustration, and an overall inability to cope with school and other daily tasks.

Other community impacts mentioned fewer times than the ones discussed above are listed in **Table 4** and include:

- How the lack of interagency, interdepartmental coordination, and seamless transition among services contributes to unmet mental health needs among families.

- The effects of behaviors such as teen pregnancies, abortions, STDs, and prostitution on mental health.
- The strain on government agencies and community clinics due to high demands for mental health care and lack of sufficient resources and staff to meet community needs.
- Incarcerations as a result of school failure and unidentified mental illness.
- Issues surrounding insufficient number of staff to carry out services.
- Lack of family supports and sufficient mental health supports to address mental health issues.
- Transient nature of families and resistance makes it difficult to connect families to resources.
- Presentation of physical health issues due to neglect of mental health issues.
- Immigration and cultural matters that affect one's social and emotional well-being.
- Lack of early assessment, identification, and intervention.
- Medication management concerns.
- Mental health referral networks.
- The impact on mental health of self-care, self-esteem, and socialization concerns.
- Lack of a family-centered, preservation approach to family mental health care.
- How operating on a traditional risk orientation toward mental health services often results in a lack of access to services -- unless symptoms fall into the high-need category.

A breakdown of community impacts by focus group is provided in **Table 4A** in **Appendix B**.

Table 4: Ways in which Mental Health Needs Impact the Community

Community Impact	Number of Mentions
Access Issues	**55**
• Stigma and Discrimination	14
• Available Services/Capacity	13
• Service Linguistic/Cultural Competency	8
• Cost/Insurance/Medi-Cal/Eligibility Criteria	6
• General	5
• Geographic Location/Social & Physical Conditions/Transportation	5
• Service Operations	4
Mental Health Issues	**23**
• Substance Abuse	7
• Depression/Suicide Risk	9
• Trauma/PTSD/Anxiety	4
• General	3
Community/Family Violence/Abuse	**21**
Social/Economic Conditions	**19**
Service Quality	**17**
Community/Family Breakdown/Hopelessness	**14**
Unaddressed/Exacerbated Mental Health Conditions/Higher Levels of Care/Poor Social Conditions	**10**
Outreach/Education/Awareness	**9**
• General	5
• Families/Parents	4
Academic Outcomes	**8**
Behavioral/Social/Emotional/Outcomes	**8**
Families/Parent High Stress Levels/Parenting Issues/Poor Social Skills/Coping	**7**
Service Integration/Continuity of Care	**6**
Negative Risky/Behaviors	**5**
Overburdened System-Law Enforcement, Schools, DMH, etc.	**5**
Juvenile Justice/Incarceration	**4**
Insufficient Number of MH Staff	**4**
Support System	**4**
Service Engagement/Benefits	**3**
Health Care Issues	**3**
Immigration/Cultural Matters	**3**
System Support/Assistance/Navigators	**3**
Sensitive Staff/Can Relate	**2**
Assessment/Identification/Intervention-Early/Better Outcomes	**1**
Child Welfare/Foster Care	**1**
Critical Developmental Period	**1**
Medication Issues/Management	**1**
Referral Network	**1**
Self-care/Self-esteem/Socialization	**1**
Service/Treatment Effectiveness/Acceptance/Utilization	**1**
Tradition/Risk Orientation	**1**
Other	**11**

VI. Existing and Needed Prevention Services/Resources

Existing Prevention Services/Resources (Q5)

The following is a listing of all the existing prevention services identified by participants across all 17 countywide focus groups. Several of the focus groups qualified their responses in different ways. One focus group indicated that they were not aware of any existing prevention services other than those offered at the agency they represented. Two other focus groups had difficulty identifying prevention services; and, a few others indicated that prevention services were either limited in their communities or the services provided were insufficient. Nevertheless, all 17 focus groups contributed to the list below.

- Alcoholics Anonymous/Narcotics Anonymous.
- Active Minds-Peer-to-Peer Advocacy Program.
- Alcohol and Drug Abuse Prevention Services.
- Asian Pacific Counseling Center, provides mentoring and after school programs for youth and their families.
- Asian Pacific Health Care Venture, provides prevention health services to adults and seniors.
- Asian Pacific Women's Center, provides counseling services for women and their children.
- Assisted Wellness Centers, client-run centers in the community.
- Big Brothers/Big Sisters.
- Black Infant Health, a program similar to Healthy Homes located in Pasadena, except that it targets at-risk African American families.
- Boys and Girls Clubs, offer summer camp programs and mentoring.
- California State University Long Beach (CSULB):
    - Counseling Center – Case Management;
    - Counseling Center – Outreach;
    - Counseling Center – Therapy;
    - Disabled Students – Mental Health Services;
    - Health Services – Mental Health Screenings and Referrals;
    - Orientation – Mental Health Information Dissemination; and,
    - Suicide Prevention Programs.
- Caregiver Support Groups.
- Case Management.
- Challengers Boys and Girls Club.
- Child Health and Disability Program (CHDP), requires every child to be examined upon entering California schools, typically done in kindergarten or first grade, includes a limited mental health screening.
- Child Health Works, a joint project among Children's Hospital, the Department of Mental Health, Valley Resource Center, and LAUSD, that provides integrated resources (mental health, physical health, and/or educational resources) in early childhood education settings to address the developmental needs of children.
- Chinatown Service Center Youth-Based Advocates.
- College Financial Aid.
- Community Clinics.
- Community Supports, various social support networks, such as family members.

> ***"It is important to point out that these are available prevention services in these community clinics, but they're available to a limited extent, just because we're always trying to get grant funds to sustain them and kind of partner with whomever we can to do them."***

- Community-based Programs:
    - Educational Programs, offer activities and socialization supports for youth and adults, such as parenting and vocational classes, tai-chi, and dance; and,
    - Outreach Programs, like the Promotoras.
- Coping and Resilience-building Skills Pilot Program, incorporates coping and resilience-building skills into an elective course for which students receive credit.
- Counseling Services:
    - On school campuses; and,
    - Grief counseling at senior centers.
- Community College Mental Health Services, include individual mental health counseling (although very limited).
- County Department of Mental Health services in North Hollywood.
- Department of Children and Family Services (DCFS) Group Housing Program, provides apartments for youth transitioning out of foster care.
- Department of Children and Family Services (DCFS) Prevention Initiative Demonstration Project (PIDP), a community-based prevention project.
- Didi Hirsch Program, assists women returning to the workforce.
- Domestic Violence Prevention Education.
- Early Childhood Centers in schools.
- Early Detection Screenings, offer general screenings for children.
- Faith-based Organizations.
- First Steps, a home visitation program that uses a therapist and child development specialist to promote attachment and healthy interactions between mother and child
- Five Acres:
    - Perinatal Program, provides a nurse who works with pregnant deaf women to teach them about pregnancy, how to obtain medical access and interpreters for the birth, as well as what services and assistance they may need after the baby is born.
    - Parenting classes for the deaf and hard-of-hearing, taught by two deaf instructors and primarily serves those who have had their children taken away from them by DCFS.
- Foster Care Family Prevention Programs.
- Free clinics.
- Gang Prevention Programs.
- Greater Los Angeles Agency on Deafness (GLAD):
    - Anger management classes (Riverside location only);
    - Mental Health Service Resource List, tailored specifically to GLAD members;
    - Parenting Classes (Riverside location only);
    - Referral System for the deaf, hard-of-hearing, and blind, includes a strong referral base for Latino families with members who are deaf or hard-of-hearing; and,
    - Teen Pregnancy and HIV Prevention Services.
- Harbor-UCLA Medical Center.
- Head Start:
    - Early Head Start, (i.e., Hope Street's Early Head Start Program), enrolls prenatal families and follows them until their children enroll in Head Start and includes mental health services to family members, not only the child.

"It's so like a finger in the dike. Everything we do here is like one person at a time, one small group at a time. In terms of the larger whole community, it would be great if there were more school counselors in all the schools so kids would have that resource."

    - Healthy/Head Start Programs.
- Healthy Births, is a prevention program that involves case management and home visitation to families at risk in seven regions of LA County.
- Healthy Homes, a national model with a location in Antelope Valley that identifies children from the time of birth and provides case management, home visitation, and general support for three years.
- Healthy Start.
- Home Health Agencies.
- Independent Living Programs.
- Infant/Toddler Mental Health Initiative, teaches parents how to work with infants and toddlers as parent-child dyads.
- Kaiser and LA Care Hospital Mental Health Prevention Programs (limited to insured clients only).
- Lennox School Readiness and State Preschool Program, a district affiliated school readiness program that provides an integrated approach to ensuring the transition from pre-school to Kindergarten among participating families.
- Libraries.
- Lincoln and Santee High Schools Youth Development/Leadership Program, students write poetry about their experiences, then create and act out productions showcasing their experiences and talents.
- Long Beach Mental Health.
- LA Best Babies Network, provides the infrastructure to support the growth, integration and sustainability of the Healthy Births Initiative by providing centrally coordinated advocacy activities and technical assistance to improve the health and well-being of women, infants, and families.
- Los Angeles Unified School District Counseling Program, supports positive relations and positive mental health through storytelling as part of the language arts curriculum.
- Mobile Programs:
    - Mobile Clinicians, service different schools.
    - Mobile Services, visits schools, community centers, and homeless shelters giving well-child exams that do not require insurance; a social worker works with the whole family, providing Mommy and Me groups, parenting groups, and child care services, all of which are particularly helpful as domestic violence issues arise.
- Mother Net, a local South Los Angeles program that provides case management and other support to high risk pregnant teens.
- National Alliance on Mental Illness (NAMI):
    - Countywide Prevention Services and Resources.
    - Family to Family, an educational 12-week group for families focused on mental health symptoms and medication.
    - Parenting classes.
    - Support groups.
    - Veterans and Consumers Programs, offered in multiple languages.
- Nurse-Family Partnership, enrolls high-risk pregnant mothers and follows both the mother and child for up to two years.
- North Hollywood Employment Program, offers screening and support for transgendered women.
- Outreach and Parenting Education.
- Parent-Child Involvement and Learning, children learn from parent experiences about culture, history, and drug and alcohol abuse in the community.

- Parents and Teachers as Allies (PATA), a prevention team approach comprised of office staff, teachers, parents and NAMI personnel.
- Partnership for Families Program, a two-year First 5-funded program developed together with DCFS that focuses on family-centered prevention and early intervention services for families with mothers at risk of substance abuse, domestic violence, or mental health issues and/or with children whose social and emotional development is at risk. This program also brings different sector services such as healthcare, childcare, education, and mental health together to meet the needs of the family.
- Peer Self-help Support Groups.
- Planned Parenthood.
- Pow-wows.
- Preventing Child Abuse and Neglect (P-CAN), trains providers who work with families with children age zero to three to develop and strengthen family relationships, identify at-risk conditions early on, and provide support.
- Private funding for community-based organizations.
- Psychiatric Mobile Response Team:
    - Case Assessment Management Program (CAMP), follows up with older patients with a high number of calls to police or fire departments to prevent future decompensation.
    - Crisis counseling to victims after critical incidents.
    - Genesis Program, links home-bound older adults to services so they can remain in their homes, preventing them from becoming displaced or homeless.
    - Prevention Services, if time permits, team members address issues, evaluate signs and symptoms, and educate families on suicide as part of the response effort.
    - Suicide Prevention Presentations/Workshops, provided to staff in emergency rooms, group homes, and DCFS on how to manage youth who are escalating, identify signs and symptoms, and criteria for hospital admissions.
- Psycho-educational Programs, focus is on cognitive behavioral change and skills development.
- Questioning, Persuading, Referral (QPR) Program.
- Recreational Centers/Programs, such as sports.
- St. John's Mental Health Needs and Symptoms Community Presentations, conducted by volunteers.
- School-based services at the elementary, middle, and high school levels:
    - After-school enrichment programs;
    - Cross-age Peer Tutoring is also effective in schools with older students helping younger students develop pro-social, coping, and academic skills;
    - Eight-week after-school internship program in which students go on field trips and learn about nutrition and sexual health;
    - Gang Prevention Programs;
    - Mental Health Services, including psychologists;
    - School Education, focus is on emotional issues and suicide; and,
    - Tutoring for children.
- School Health Centers, provide screenings (such as Patient Health Questionnaire 9 [PHQ9], depression, prenatal, and post-partum screenings), health education/prevention for chronic diseases, short-term counseling, and youth development/educational services.
- Services for the Deaf and/or Blind.
- Shelters.
- "Sister to Hermana" and "Brotherhood," volunteer administered LA Southwest College monthly support groups for women and men on campus, addressing pertinent issues such as domestic violence and interpersonal relationships.

- Small Learning Communities in schools, smaller more personal learning environments that engage youth and foster a sense of community and belonging as a means of promoting student learning and emotional and social well-being.
- Special Needs Demonstration Site Project, a First 5 California funded project designed to work with professionals across sectors to support young children who have a broad spectrum of special needs.
- Stepping Up to School Readiness, a mental health consultation program in pre-schools. Mental health providers coach and train teachers on the pre-school site to identify social emotional issues, address the whole child, and strengthen family relationships.
- Strengthening Families Program, a training model sponsored by the Center for the Study of Social Policy that works directly with families in early education settings to build the capacity of both the family and early childhood providers to develop supportive relationships, reduce stress, and improve the social and emotional development of the children.
- Suicide Intervention Training, uses school staff to teach students how to assess and de-escalate suicide risk.
- Talking Circles.
- Center for Non-Violent Parenting, a Los-Angeles based program that educates parents and the community.
- The Community Treatment Center.
- Healthy Advocacy Response Team (HART), exists in every district community college to prevent sexual assaults against women; operates by using a multi-disciplinary team (including sheriffs, counselors, etc.) that address issues of domestic violence and sexual assault.
- Life Skills Program at Harbor College, serves as a student referral resource and offers crisis intervention, as well as limited screenings for alcoholism and depression.
- Students against Drugs and Alcohol, run by an LCSW and serves as a college campus support group for chemically dependent students in recovery.
- Transitional Housing/Residential Centers.
- Tutoring, includes computer skill building.
- United American Indian Involvement (UAII) Programs.
- UCLA's Early Developmental Screening Initiative (EDSI), a strategic partnership that brings pediatricians, early care providers, and family support professionals together to help parents play an active role in screening and recognition.
- Urban League:
    - Job Placement Services;
    - Job Corps Program; and,
    - Worksource Program.
- Veterans Administration Programs:
    - Alcoholics Anonymous;
    - Anger management;
    - Good primary health care and comprehensive exams;
    - Peer Support Groups;
    - Process Groups;
    - PTSD Clinic; and,
    - Recovery Center Group, helps participants deal with substance abuse problems and dual diagnosis issues.
- Visiting Nurse Programs Home Nurse Outreach Program.
- Welcome Baby, a First 5 LA-funded universal home visitation pilot program that uses parent coaches who educate prenatal mothers about breastfeeding, child development in the first year, and parenting skills.

- Wellness Centers, Los Angeles County.
- Youth Activities and Parent Centers in schools, designed to engage and support families.
- Youth Community Drop-in Centers.

Needed Prevention Services/Resources (Q5a)
All 17 focus groups identified a number of needed prevention services and/or resources as reflected by the list below. The needed prevention services are organized by type of service/resource and listed from highest to lowest number of needed services/resources cited under each service/resource type.

Specific Services and Resources including Counseling and Support Groups

- Pre-school services (e.g., Mommy and Me classes).
- Employment activities for youth that are meaningful.
- Youth services available in consumers' own language(s).
- Camps for at-risk youth.
- Accessible afterschool activities and sports for youth.
- Mentoring programs for children and youth, like Big Brothers.
- Teen screenings for mental illness.
- Drug and substance abuse rehabilitation services.
- Gang prevention programs.
- Suicide Prevention that is Internet-based, giving youth a place to chat, share their feelings, and connect with resources.
- Mobile prevention teams to engage community members in the field and address gangs, violence, homicide, suicide, and depression.
- More programs and services in jails for women.
- Services for undocumented individuals or those without medical insurance.
- Programs dealing with immigration issues, supporting families as newcomers and on an ongoing basis who are dealing with significant separation issues among parents and children; establishing a bridge; and providing rituals to help people reconnect, deal with their loss, and adjust to urban settings.
- Universal screenings and early identification methods that are non-threatening and connected to services (the connection to services is key to preventing people from getting lost in the referral system).
- Services that identify hearing-related needs.
- A service and information clearinghouse for all categories of hearing (hard-of-hearing, hearing loss, and deaf). The clearinghouse would provide parents/families, physicians, and service providers access to "neutral" information on available services, resources, and literature.
- One-stop Comprehensive Services offering screening, assessment, and identification of individual and family needs and linkages to appropriate services.

"This family needs mental health. They need individual counseling. They need family therapy. They need to be referred to GLAD. They need a support group. They need educational support for IEP in the Regional Center. Whatever it is and somebody who knows and is familiar, a team and so that family now will get all the resources that are available in the community or have someone that's connecting them, linking them to those services like a clearinghouse or One-Stop Comprehensive Services Center."

- Wellness Centers that are culturally-, ethnically-, and language-specific.
- Wellness Centers with flexible hours for children and families.
- Centrally located Clubhouse/Wellness Centers serving as a multi-purpose service center at which deaf, hard-of-hearing, and blind not only receive general support, but also can receive personal help interpreting a notice from a pubic agency, the Department of Water and Power, for example; making a telephone, video, or teletypewriter (TTY) call to someone they need to access; dealing with social barriers such as discrimination; and, obtaining an interpreter for a meeting with the doctor.
- Transitional Residential Centers (TRCs).
- More drop-off centers and diversion services.
- Services for the deaf with developmental disabilities.
- Increased comprehensive mental health services for the Indian/Native Americans throughout the county.
- Prevention services for veterans.
- Affordable housing.
- Diversion programs.
- Emergency hospitalization beds.
- Group homes for entire families, provides a place for kids and their families to go to get some counseling and support when parents are using drugs, for example.
- Support groups for families in designated places.
- Free Yoga and Tai Chi classes.
- More pow-wows.
- Sports programs for youth.
- Increased mental health services, such as counseling and support groups.
- More mental health counselors in the schools to meet students' needs for emotional counseling.
- More Counselors and therapists, especially those with experiences that mirror their patients.
- Alternate counseling delivery mechanisms, including telephone and online supports and services.
- Mentors and Community Role Models, including motivational speakers and business leaders.
- Peer support and peer-provider support groups/networks to exchange best practices.
- Support groups, peer-to-peer connections, and group and individual psychotherapy for mothers.
- More peer-programs for teens, such as Cedar-Sinai Hospital's Teen Line, that provides a warm line for teens to call for mental health information and support.
- Grief groups for parents who learn that their child has a disability such as hard-of-hearing, deaf and blind, or any other disability.
- More hard-of-hearing support groups for different categories of hearing loss. The Hearing Loss Association of America in Los Angeles offers support groups for individuals with hearing loss, who have not been identified as deaf. However, those who are hard-of-hearing are less likely to be identified as disabled, and as a result, services are not as accessible to

> ***"There is limited or no housing available for the mentally ill population. Board and care centers are closing down."***

> ***"They [formerly incarcerated youth] wanna live better but no one's willing to hire them. Then what are they gonna do? They're gonna turn back to their roots, to what they've been doing, to what they know."***

them. These marginalized categories of deafness could benefit from support groups targeted at their peers.
- Support groups that would reduce isolation and teach parents and children about deaf culture and how to handle the disability.
- General (multi-faceted) support groups for deaf children and parents with deaf children.

Outreach, Education, and Awareness Services and Resources
- Community-wide education initiatives about mental health.
- Community education across populations.
- Community outreach.
- Promoting mental health education and awareness in nontraditional ways.
- Strategies to communicate the PEI message to communities.
- More public awareness of mental health using an asset-based approach.
- Programs/activities to increase community awareness of the signs and symptoms of mental illness in order to increase community support.
- Information about mental health issues and services for students and parents on college campuses, such as California State University, Long Beach.
- Programs that can educate people and change their thinking about mental health.
- More trainings regarding mental health for consumers, family members, teachers, law enforcement, and others with whom clients come in contact.
- Training for trainers, providers, professionals, and parents.
- Comprehensive training and assessment for school-based staff to better evaluate children's needs and treatment plans in an effort to reduce misdiagnoses, and provide efficient and appropriate care.
- Cross-training (i.e., transfers of knowledge) for community-based professional partners.
- Education for youth about self-esteem, bullying, and dealing with peer pressure.
- Training on mental illness to emergency care providers, primary care doctors, pediatricians and teachers.
- Outreach to increase awareness of existing services.
- Outreach and education to parents about available services.
- Strategies to communicate and educate families about PEI and mental health.
- Mental health education designed to reduce stigma.
- Community education provided via the media, schools and internet about mental illness, using sensitive terminology such as "behavioral health" to overcome the stigma associated with mental health.
- A universal and primary prevention campaign that reaches the entire college campus population, decreases stigma, increases mental health awareness, and creates a culture change among the student body to normalize positive mental health.
- A public education campaign about 'mental health' that uses friendly and culturally sensitive language and avoids fear-based messaging.
- Change the terminology from "mental health" to behavioral health or wellness in order to minimize stigma and increase public awareness.
- Culturally appropriate language in messages.
- Mental health education and awareness should be messaged wherever seniors receive services.
- Waging a media campaign with the message, "It's not normal to feel sad if you're an older adult."
- Parenting leadership outreach programs like the Promotoras model.

- Parenting programs, providing education and resources to families, linking these services to community resources and libraries.
- Forums that train parents how to do outreach and connect with other parents in the community.
- Parent leadership training.
- Parenting education and increased education and awareness opportunities for children as early as the 3rd grade.
- More parent education, possibly mandating parenting classes similar to Lamaze classes.
- Parent education for parents with children of all ages and for adolescents to prepare them for parenting.
- Parenting education on mental illness symptoms.
- Education about substance abuse and parenting at different points in children's development to help parents identify and deal with behavioral and mental health problems.
- Multicultural parenting training
- Strategies to educate the business community about the link between economic self-sufficiency, mental health and physical health.

Specific Strategies and Approaches

- Identification and expansion of effective existing services, rather than creating new ones.
- Culturally-specific prevention strategies for effective outcomes.
- Integrating emotional social well-being into other systems of care and professions (e.g., public health nurses) which increases mental health awareness and points of intervention.
- A "hub" model of service provision which creates systems of care with a client-centered approach.
- Centrally-located services in communities that support the deaf and blind in various ways, either by providing access to information and resources, general support with day-to-day issues, such as getting service from the Department of Water and Power, comprehensive services, and support groups.
- Prevention education programs that teach individuals and families what a healthy family is and how to be a good parent.
- Coordinated, integrated, and family-centered services.
- Holistic services that are family-centered.
- More family-focused, comprehensive care for families.
- Family resource centers that spearhead training.
- Identify models that support and impact the family structure when children are the identified patients.
- Identify effective non-clinical prevention models and integrate into service plans and strategies.
- Non-traditional (i.e., non-clinical) methods of service delivery.
- Early mental health consultation system that is connected to early care and education sites and integrates medical needs, educational needs, developmental/disability needs.
- Services that accommodate the full spectrum of needs, from 'no diagnosis' to 'chronically mentally ill.'
- Safety net programming to track other interventions.
- Strategies that engage pediatricians in PEI efforts (e.g., reimburse physicians for conducting screenings.)
- More free community resources like those in wealthier communities, such as youth programs, recreation centers, or even malls where you can hang out.

- More youth developmental activities to build social skills, help youth find places to fit in, and keep youth engaged in summer and year round activities.
- More constructive activities for youth.
- Approaches to improve the economic condition of families living in poverty.
- Jobs willing to pay above minimum wage.
- Employment programs in native languages.
- More job opportunities for those persons who have one or two strikes.
- Reform of, or modifications to, the immigration law and increased Border Patrol as a means of raising employment opportunities.
- Efforts to replace "small town life" that will enable people to connect with one another and to get spiritually centered.
- Socialization activities that build a sense of community.
- Incentives provided to colleges and universities to promote the Mental Health Field (e.g., CAL-SWEC).
- Tele-medicine; laptops with web cameras to increase access to service providers and the sharing of medical histories.

Services and Resources that Increase Access

- Increased service access and availability so that there are places to refer people to.
- Increased mental health services offered on college campuses.
- Access for CSULB students to insurance to get services.
- Affordable transportation.
- Free, low-cost, and accessible transportation (i.e., tokens, vouchers, etc.).
- Funds for transportation to access services.
- Access for CSULB students to county mental health services.
- Culturally-competent prevention services to be integrated with existing services in order to minimize stigma and maximize access.
- More culturally- and linguistically-competent services that are provided where community members are at in order to minimize stigma -- such as schools, adult health care centers, and other non-traditional locations.
- Services for dual language learners (currently most assessment tools are not norm-referenced for dual language learners which makes findings suspect).
- Programs knowledgeable of Chinese culture and traditions.
- Comprehensive bi-lingual (e.g., English/Spanish) health services for families, especially with the closing of Martin Luther King Hospital in the Compton area.
- Culturally-appropriate services situated within local neighborhoods.
- Childcare for families accessing services.
- Mental health services available with extended hours/days.
- De-stigmatizing mental health as part of CSULB's student orientation process.

Staff and Provider Education, Training, and Recruitment Service Needs

- Trainings for those who train providers.
- Trainings/education for providers.
- Simultaneously train professionals to develop a common vocabulary and understanding.
- Intensive training for CSULB staff that have regular contact with students.
- A cadre of well-trained mental health consultants with expertise in the developmental needs of children 0 to 5; and, who can work at sites to build a high quality nurturing environment that is able to address the social-emotional needs of the children without referring them out for services.

> ***"There needs to be training to assist clinicians to recognize specific needs with a self-identified American Indian on what to do or how to treat them. People don't know what it's like to be American Indian … they need someone they can talk to, to connect with someone who understands what it means to be Indian."***

- Support workforce education and training to increase mental health professionals with programs such as Recovery Specialist Certificate Programs, human services programs, and drug and alcohol certificate programs.
- A highly trained trans-disciplinary workforce with expertise in the social-emotional development of children.
- Additional training for DCFS personnel.
- Cultural competency training for providers.
- Continuing education for everyone in the social services field.
- Financially supported licensed clinicians and social workers at the Greater Los Angeles Agency on Deafness (GLAD).
- Increased mental health professionals (such as LCSWs, psychiatrists, prevention and early intervention experts) on community college campuses in order to increase timeliness of services.
- Increasing the number of health educators serving older adults.
- More mental health therapists.
- Higher-level treatment staff, such as psychiatrists.
- Prevention-focused program staff who are trusted in the community and can perform effective student outreach.
- Certified agencies to provide services.
- Support service providers, volunteers, trained staff, and in-home services not only for the deaf, but for the blind, too.
- Bilingual/bicultural therapists.
- More qualified staff.

Funding and Resources

- Funding for needed services.
- Program/service expansion in order to build capacity and sustainability.
- Increased county financial support of mental health services in educational venues.
- Funding and resources to expand the El Monte Police Department programs.
- Funding for the CSULB Suicide Prevention program to promote a more Evidenced-based Approach.
- Additional funding for existing programs, including HART, Life Skills Center, and support groups.

- Funding and resources to meet the need for counseling services.
- Increased funding to cover the provision of food and childcare costs for families receiving services.
- Funding for outreach so that consumers may speak not only to people in the community, but to people involved with law enforcement or in public jails (similar to NAMI's "In Our Voice" program.)

Location-based Services

- Prevention programs tailored to each community.
- In-home services.
- Utilization of schools as community hubs.
- School-based health centers in every school (elementary, middle, and high school) that address both health and mental health needs.
- School-based services, after-school programs, and high school tutoring by college-age students.
- School-based programs for parents, particularly for fathers.
- Recreational opportunities and recreational spaces.
- Services through community based organizations.

Promoting Service Integration and Continuity of Care

- Service integration.
- Link and integrate Department of Mental Health (DMH) and Department of Health Services (DHS) to improve communication, sharing of information, outreach, and awareness of services.
- A model of comprehensive, integrated health care in which health care clinics approach mental health as part of the health care continuum with mental health professionals as part of the health care team.
- Integration of mental health services with others services (e.g., improve communication between the schools, community, and criminal justice system) in order to reach the entire family.
- Streamline access to mental health services.
- Development of a continuum of care linkages.
- Follow-ups for 5150 releases.

"One of the things that is needed is that we look at mental health as part of the continuum of health care. As long as they're coming into a clinic to get other types of services, the mental health/health care screening should be part of any other screening that we're doing for anything as well and that is tied into that, not something separate. Integrated behavioral health care."

Collaboration/Partnerships/Teams

- Collaboration between education and mental health.
- Collaboration among faith-based organizations and services providers.
- More partnerships/collaborative programs with other agencies such as law enforcement and mental health.
- Collaboration among social service agencies mitigating against isolation.
- Utilize Emergency Outreach Bureaus (EOBs) and other existing divisions within the Department.

Strategies to Improve Social/Economic Conditions

- Affordable childcare.
- Affordable housing.
- Employment opportunities.

System Supports, Assistance, and Navigators

- Services that support and address the family, not just the individual.
- Re-entry support/rehabilitation services for those transitioning from the jails.
- Services for women and men returning to the workforce.

Case Management

- Case managers to follow-up and ensure that people navigate the mental health system and access resources.
- Case management to help parents link to needed services.

Community and Client Involvement in the Mental Health Process

- Engagement of parents and funders in discussing effective comprehensive prevention approaches.
- Opportunities for parent involvement in the mental health process.

Other

- Anger management classes for young men and women.
- Physical spaces or centers for the Native American community including an outdoor space for ceremonies.
- Substance abuse assistance and programs for youth and families.
- Health care providers who are more sensitive to mental health issues and application of services.
- Increased community engagement in systems of care to reinforce programmatic ownership and accountability.

Priority Prevention Services/Resources (Q5b)

When the 17 focus groups were asked to prioritize the needed prevention services they had listed in response to the prior question, they selected three priority services, as presented in **Table 5.** Three focus groups did not have an opportunity to prioritize needed prevention services; and, four focus groups cited one additional priority each. Please note that the priorities listed in **Table 5** are not listed in rank order.

"If you look at it from a point of comprehensive healthcare and take out the mental health, take out the behavioral health, take out all those words that would stop people and just think of 'How can I provide you the best comprehensive healthcare possible?' Well, that's the head-to-toe mental health improvement."

The priorities identified by the 14 responding focus groups reflect prevention services and/or resources that would:

- Expand and integrate
  - school-based and community-based services;
  - communication systems among probation, schools, providers, and other services;
  - prevention services together with school health and community clinics; and,

    - culturally- and linguistically-appropriate services to more effectively meet the needs of consumers.
- Engage parent and family participation in
    - family centered services and activities;
    - developing coping strategies to handle issues that may arise among immigrants adjusting to a new culture;
    - designing and implementing effective service strategies; and,
    - sharing the history and traditions of their cultural backgrounds and experiences in their communities.
- Develop new and improved multi-disciplinary collaborative efforts and linkages across prevention services, but also within college campuses, and within and across the larger system of service sectors and agencies.
- Train and increase the number of mental health service providers, professionals, and consultants in general; and, specifically train and increase the number of mental health professionals on college campuses, those individuals who are capable of training providers, and health educators who serve older adults.
- Offer affordable and accessible transportation.
- Establish centrally-located physical places and spaces at which underserved cultural populations feel comfortable (i.e., American Indian families, deaf and blind, and emancipated foster youth) and that provide:
    - One-stop comprehensive services;
    - Clubhouse/Wellness Center-type services with available resources and assistance to help consumers navigate everyday challenges; and,
    - Recreational opportunities.
- Increase public awareness and community-wide education efforts designed to inform communities about mental health issues, engender community members' trust in the mental health system, and bridge cultural and linguistic gaps.
- Enhance youth development activities, internship programs, and counseling services that guide youth on a path toward constructive social activities, job opportunities, and healthy adulthood.
- Provide early mental health consultation, mobile teams conducting outreach and education in community schools and churches, and/or other services that focus on recognizing the early signs of symptom development, and intercepting the presenting symptoms before the individual reaches a crisis state.

Four focus groups also offered the following fourth priorities:

- Drug and substance abuse rehabilitation centers;
- New language around mental health, moving toward a more positive "wellness" approach in order to combat stigma and discrimination and increase awareness;
- Anger management; and,
- Comprehensive strategies to address mental health issues.

Table 5: Priority Prevention Services/Resources (n=14)*

Focus Group	Priority 1	Priority 2	Priority 3
Asian Pacific Policy and Planning Consortium	More funding to expand culturally- and linguistically-appropriate services.	Services that engage parents in the design of effective and comprehensive prevention strategies.	No Response.
CSU Long Beach - Suicide Prevention and Intervention Team	No Response.	No Response.	No Response.
Community Clinic Association of Los Angeles County	Expansion of existing school- and community-based programs using a comprehensive, integrative approach.	Prevention services that are integrated into existing school health services and community clinics.	No Response.
DCFS Transitional Housing Program	Affordable transportation.	Recreational spaces and opportunities.	Jobs that pay above minimum wage.
GLAD	Centrally-located Clubhouse/Wellness Centers.	One-stop comprehensive services.	No Response.
ICARE Network	Early mental health consultation that focuses on 'recognition and response.'	Training for mental health service providers, professionals, consultants and even those who train providers.	No Response.
LA Coalition of School Health Centers	Expansion and integration of existing services to more effectively meet needs by filling gaps in existing programs (not duplicating them), increasing communication between agencies (probation, school, providers), and enhancing family involvement.	Programs aimed at giving parents the tools to cope with stressors related to immigration and to address issues with their children early on.	Youth development activities, internships, and year-round programs.
Los Angeles Community College District	Drastic need for increased programs and services.	Increased mental health professionals on college campuses.	Improving linkages between community social services and campus communities, and increasing linkages within the campus community (such as, student-teacher, teacher-administration, classroom-counseling services, etc.).
LA County Commission for Children and Families	Free accessible transportation.	Efforts to strengthen people's trust in the system (in terms of language and cultural differences).	No Response.
LA County Mental Health Commission	Increased public awareness.	More family-centered services.	More multi-disciplinary collaborations to allow for better service integration.

Focus Group	Priority 1	Priority 2	Priority 3
LACDMH Children's Outpatient Programs	No Response	No Response.	No Response.
LACDMH Psychiatric Mobile Response Team	Mobile teams devoted exclusively to prevention to provide outreach and education in the community, schools, and churches.	Prevention services that are available and accessible to the "walking wounded" in the community who have not yet reached the crisis point but are in need of services.	No Response.
National Alliance on Mental Illness	Education and training.	Linkages and collaboration among systems.	Intercepting mental health issues at points early on in symptom development.
TAY Residents of Dorothy Kirby Center	More mentors and counselors who can show youth various healthy pathways to adulthood.	Counselors to show and guide youth toward job opportunities.	No Response.
Older Adult System of Care	More health educators who serve older adults.	Planning community-wide education initiatives.	Waging a media campaign with the message, "It is not normal to feel sad if you are an older adult."
United American Indian Involvement	Increased parent involvement and sharing of culture and history.	Central, physical spaces and places for Native American families to go.	Constructive social activities for youth.
US Veterans, Inc. – Double Trudgers	No Response.	No Response.	No Response.

Note: Priorities not listed in rank order.
*Three focus groups elected not to prioritize the needed prevention services.

Locations for Prevention Services/Resources (Q5c)

Table 6 presents the locations at which the focus group participants would like to see prevention services offered.

As shown in the table, locating prevention services at or near schools was the most preferred by six of the 13 responding focus groups. Community agencies and organizations closely followed schools as a preferred location, supported by five focus groups. In addition, three focus groups each indicated that centrally-located and comfortable places, as well as faith-based organizations, are worthy locations for prevention services. Parks and recreation centers and senior centers were also cited by two focus groups. Another 19 locations were mentioned by the 13 responding focus groups as shown in the table below. A breakdown by focus group is also provided in **Table 6A** in **Appendix B**.

"Schools are one of the most universal places to meet kids if you're talking about children and youth. And although it may seem self-serving, I really think that schools may be one of the only places where we can universally meet the kids that are sort of flying under the radar, not being detected by a mental health system or a medical provider. I think schools are critical to whatever prevention and early intervention sort of programs or systems that we build."

Table 6: Prevention Service Locations

Prevention Service Locations	Number of Groups (n=13)*
School Sites	**6**
Community Agencies/Centers/Organizations (i.e., children's agencies)	**5**
Easily accessible, centrally located, and inviting, comfortable places	**3**
Faith-based Organizations	**3**
Parks and Recreational Centers	**2**
Senior Centers	**2**
Beauty Parlors	**1**
Community Colleges	**1**
Community Health Centers/Clinics	**1**
Department of Motor Vehicles	**1**
Early Childcare and Education Sites	**1**
Family Resource Centers	**1**
GLAD	**1**
Homes	**1**
Hospitals	**1**
Jails	**1**
Laundromats	**1**
Law Offices	**1**
Non-traditional, Non-service Public Spaces	**1**
One-stop Comprehensive Services	**1**
Primary Care Physician's Offices	**1**
Regional Centers	**1**
Residential Care Facilities	**1**
Youth Centers	**1**
Where the Need is	**1**

*Four focus groups did not provide prevention service locations.

VII. Existing and Needed Early Intervention Services

Existing Early Intervention Services/Resources (Q6)

The following is a listing of all the existing early intervention services identified by the participants across the 17 countywide focus groups. Similar to focus group responses regarding identifying prevention services, several of the focus groups qualified their contributions to the list of early intervention services. Six focus groups indicated that they were having trouble identifying early intervention services; another focus group was not aware of any existing early intervention services other than those offered at the agency they represented. In addition, three focus groups felt the early intervention services they could identify were limited in number and in scope. Nevertheless, all 17 focus groups contributed to the early intervention list below.

> ***"The programs that we have aren't effective 'cause they're like a bandage or like stitches. They're not there to fix the problem. They just make it go away."***

- Active Minds, uses a peer-to-peer counseling model.
- ADOD Programs.
- Adult Day Health Care Centers, with LCSW staff.
- Adult Protective Services.
- Alcohol and Drug Counselors.
- Alcoholics Anonymous, available on college campuses.
- American Indian Faith-based Centers, such as the Indian Revival Church in Whittier which offers men's prayer, talks, "holy humor."
- Birth-to-Five Programs.
- Boys and Girls Club.
- CalWORKs.
- Case management:
    - Seniors Case Management Services; and,
    - Case manager and/or Resource Specialist at schools to work with families and engage students in skills-building groups based upon screening results.
- Center for the Assessment and Prevention of Prodromal States (CAPPS) at UCLA, research clinic focusing on taking care of symptoms that may precede the onset of mental illness.
- Child Counseling Services, DMH-funded.
- Child Health Works.
- Children's Hospital.
- Church.
- Youth and Family Programs.
- Community Built-Mental Health Programs.
- Community Centers.
- Community College Student Services, responds to crises and refers students to community-based services.
- Community in Schools.
- Counseling/Therapy Services:
    - Therapy for children and adults.
    - Parent support groups at Marlton High School, serves families and children between the ages of zero to three who are deaf.
    - Short-Term Counseling.
    - Support groups for youth and their families.
    - Teen groups.

    - Teen hotlines.
    - San Fernando Valley Mental Health Clinic, provides counseling for those without insurance coverage.
- Courts.
- Daniel's Place, a Step Up on 2nd Street Program in Santa Monica, serves teens experiencing their first "break" or episode of serious mental illness.
- Domestic Violence Case Management.
- Domestic Violence Shelters.
- "Wellness Wednesday," a recently established drop-in program.
- Early Childhood Centers in schools with a parenting component.
- Early Teen Parenting Program, provides education, as well as needed staples (name unknown).
- El Monte Gabrieleno Tongva Youth Development Center.
- Extended Opportunities and Services.
- Faith-based Home Outreach Programs, such as buddy systems and senior adoptive families.
- Family Development Networks.
- Family Reunification Program, a Department of Children and Family Services program.
- Five Acres:
    - Developmental assessments of children 0-5; and,
    - Parenting and Perinatal Programs, staff note early signs of developmental or mental health issues and make referrals among the deaf and blind population.
- Foothill Family Services, trained professional staff who work in early childhood settings with children 0 to 5.
- Full Service Partnerships, includes a 0 to 5 component, as well as services provided to teenage mothers.
- Gang intervention programs.
- Genesis-services for Older Adults.
- GLAD's Independent Living Skills Program.
- Glendale Clients Helping Clients, an early intervention, peer-to-peer support and education recovery program.
- Harbor College's Life Skills Program, offers crisis intervention services.
- Head Start, Early Head Start, and Healthy Start.
- Help Lines, staffed by mental health professionals.
- Hospital Services.
- Holy Angels, offers peer counseling, parent support groups, and referrals.
- IMPACT, a prevention and early intervention program.
- In-home services.
- Judges.
- Juvenile Mental Health Court, East Los Angeles.
- K-12 Schools.
- Libraries.
- Long Beach Day Nursery, an early mental health consultant is on staff.
- Long Beach Senior Police Partners, trained to handle crisis and utilize referral systems.
- L.A. Bridges, programs that provide case management and counseling for high-risk kids.
- Los Angeles Child Guidance Center.
- Los Angeles County Programs for Children 0 to 5, offers prevention, coordination, and home visitation targeting high risk families with children 0 to 3 such as:
    - Best Baby Collaborative;
    - Early Head Start;
    - Nurse-Family Partnership; and,

    - School Readiness Programs (funded by First 5 LA).
- Los Angeles Unified School District (LAUSD) Impact Program.
- Marlton High School, offers a half-day program for children 0 to 5 who are deaf.
- Mental Health Centers with programs for children 0 to 5.
- Mental Health Information, distributed informally to students via word of mouth, clubs, and sports venues on college campuses.
- Mentors and Mentoring Programs.
- National Asian Pacific American Families Against Substance Abuse (NAPAFASA), addresses the alcohol, tobacco, drug and gambling issues of Asian Pacific Islanders.
- Non-public Schools (NPS), service children who are Seriously Emotionally Disturbed (SED).
- Nursing Programs, offered through First 5 LA.
- Parenting Classes.
- Parent-Teacher Conferences.
- Partnerships for Families.
- Police Activities League (PAL) programs.
- Police Departments.
- Primary Health and Mental Health Care Service Integration, available primarily for the most extreme cases.
- Project ABC, a SAMHSA-funded project at Children's Institute (CII) working with families and children placing a heavy emphasis on screenings.
- Psychiatric Mobile Response Team.
- Psychological Services.
- Regional Centers.
- School-based Resources, such as tutoring.
- Screening Services:
    - At schools;
    - Child Health and Disability Programs, well-child programs screen students and make referrals for mental health services; and,
    - Teen screenings.
- Social Workers.
- Southern California Indian Center (SCIC).
- Spiritual Center in Whittier.
- Student Services on college campuses, provide some mental health services, assessment, and referral.
- Substance Abuse Programs, tailored to college students, designed to catch youth as they start using alcohol and/or drugs and involve the whole family.
- System Navigators, available to help clients access services.
- Teachers.
- Therapeutic Pre-school, provides early intervention for emotionally disturbed children 0 to 5.
- Transition-age Youth Programs.
- Tribal Assistance and Support.
- United American Indian Involvement (UAII):
    - Seven Generations Counseling Services, provides mental health services; and,
    - Central High School, offers homework assistance, one-on-one meetings with teachers, after-school tutoring, and exposure to college.
- Universities.
- Urgent Care Centers.

"CHDP assumes that there's both a screen and effective screening tool and that you can identify kids early with. Many providers don't use the available screening tools because it's time-intensive sometimes, or it felt like it is not effective. But I think most commonly the reason they don't screen is because they don't feel like they have any place to send them after they've identified them."

- Veterans Administration Programs.
- Wellness Clinic, serves individuals diagnosed with schizophrenia.
- Westside Infant Family Network, provides services whether or not the child has a formal diagnosis and regardless of families' insurance status or ability to pay; also, provides consultation to the agencies participating in the network.

Needed Early Intervention Services/Resources (Q6a)
All 17 focus groups identified a number of needed early intervention services and/or resources as reflected by the list below. The needed early intervention services are organized by type of service/resource and listed from the highest to the lowest number of needed services/resources cited under each service/resource type.

Specific Services and Resources including Counseling and Support Groups

- Early mental health consultation.
- Early identification screening.
- Intervention programs for early onset of mental health symptoms.
- Early intervention programs at the preschool level.
- Evidence-based early intervention programs.
- Mental health diversion programs.
- Expansion of existing services, such as the Dual Recovery Anonymous (DRA).
- Child care services.
- Residential services.
- Services for short-term therapy in school settings (counseling for up to a year currently does not exist in schools).
- Gang intervention programs.
- Substance abuse programs for pregnant mothers.
- Suicide prevention services and training.
- Drop-in transitional services.
- Language support for school-site programs.
- AB3632 juvenile service triage.
- Services for homeless who are deaf that help them obtain the means to take care of themselves and teach them how to advocate for their own care.
- Interpreters for the deaf, and the deaf and blind, at medical offices who can communicate with physicians about their health and mental health needs; and who also have knowledge of medications and can help the deaf/ deaf and blind communicate to the physician about their medication and how to manage it.
- Interpreters for the deaf who sign and speak Spanish for those deaf who are third language speakers.
- Teen drug and alcohol programs for the deaf.
- Mentoring programs for transitional youth (which may tap into entertainment industry for support).
- Transition-age youth programs in Los Angeles County.

"There should be a mentor program developed for transitional youth. I really feel in today's age that there are adults who would take on a 'mentee' in a transition—a high school senior let's say, and help to make the commitment, to that person. And the entertainment business. That actually is an area with people who have great hearts who want to do business for the community, believe it or not. And I think that should be tapped. "

- More social support services that focus on the group, such as peer-run groups, health education/support groups, and youth groups.
- Mentors and counselors that can help emancipated foster youth self-manage and set goals.
- Mentorship and role models for youth, and more counselors and therapists who understand what youth are experiencing.
- Prevention and early intervention for older adults in ethnic communities using the Ethnic Service Extender program.
- Services for homeless seniors.
- Peer-to-peer programming and programs utilizing a peer counseling for older adults, similar to the Promotoras model.
- Support groups for older adults, such as bereavement groups.
- Family-centered services along with community supports such as transportation.
- Family centers with parenting tips, advice, check lists, weekly classes.
- Fatherhood and parenting initiatives for dads, especially in the adoption program.
- Family Resource Centers.
- Universally available family-centered therapy that would consider children on probation under the family therapy umbrella.
- Family counseling that addresses family issues in regards to cultural gaps.
- Resources and services to help alleviate family stress, such as early family counseling and couples counseling.
- Peer mentors.
- Support groups, especially peer support groups.
- Talking circles.
- Individual counseling and therapy in clinics for community members to talk about problems, identify early symptoms, and problem-solve.
- Hotlines that are more personal and utilize trained staff.
- Access to crisis hotlines, referrals, and resources.

Staff and Provider Education, Training, and Recruiting

- Effective training for doctors.
- Theory-based training for nurses on how to talk about mental health, especially for those who provide home visitation services.
- Mandated training for physicians, hospital and emergency room staff, and clinicians about the deaf, how to access interpreters for them, and how to access other assistance they may need in order to be able to communicate with the health or mental health care professionals.
- Education for existing mental health providers on basic information about the deaf, and deaf and blind communities.
- Theory-based core training across sectors (physicians, teachers, family specialists, mental health professionals) on normal childhood development.
- Comprehensive knowledge- and theory-based training about mental health for the 0 to 5 provider population.
- Theory-based training on how to diagnose mental health issues in infants and young children.

> ***"DMH is doing service extended training in English and Spanish which is great. We have a program serving Chinese older adults. We're going to have to adapt all of that training for our Chinese service extenders. We need that in the Armenian community. We need it in the Vietnamese community. We need it."***

- Theory-based training that focuses on how to view the family system across multiple domains.
- Training for clergy and law enforcement so they can provide more effective early intervention services.
- Train academic counselors and other staff on college campuses to identify early warning signs of mental health issues, create awareness of available support services, and knowledge about what to do when noticing students in need of support.
- Residential care facility staff training on identifying mental health concerns in older adults.
- Staff trained in co-occurring disorders.
- Better training of mental health counselors on effective, cutting edge therapies.
- University programs and curricula that serve as pipelines for more people to pursue and obtain licenses, certificates, and/or degrees in the mental health services field.
- Qualified staff to provide early intervention in the K-12 school system (in many school Individual Educational Plan [IEP] meetings, those present know that the child would benefit from counseling, but because the number of counselors is limited, the service is not mentioned).
- More staff (psychiatry and therapists).
- Recruit and hire case managers.
- Bilingual and bicultural counselors and/or therapists.
- Enough licensed, certified, degreed, and qualified professionals to meet the mental health needs of the deaf and blind community.
- Include site and home visits as part of the job description for DMH workers.

Outreach, Education, and Awareness Services and Resources

- Educational programs.
- Increased public education efforts on mental health topics.
- Media should step up to raise awareness/educate the public about mental health.
- Increased training that will build people's skills to recognize the signs and symptoms of mental illness.
- Appropriate mental health curricula that teach families about mental health illness.
- Increased education and awareness for older adults.
- Teachers ought to be educated about mental health issues.
- Educate school personnel and families how to identify signs and symptoms of mental health problems and how to manage them.
- Increased effective education and outreach activities to raise people's awareness about available services.
- More media to educate the community and create the political will to sustain and fund the needed services.
- More community outreach programs similar to the Promotoras model.
- Outreach programs in churches, temples, and community centers during weekends.
- Use the Internet as a way to increase awareness.
- Use PTAs to increase awareness and educate parents.
- Motivational speakers to inspire hope, share history and experiences from their own lives.
- Development of language about mental health that is "… acceptable, culturally competent, non-judgmental, non-stigmatizing, and person-first."
- Standardize mental health terminology, by defining mental health, symptoms and illnesses.
- Simplify mental health terminology.

Location-based Services

> ***"This whole idea of co-locating services or however, you want to call it, does tap into the idea that needs are family-centered."***

- More medical and mental health services are needed in the community as many people rely on the schools to provide these services.
- Mental health services available in community clinics to refer people to immediately after problems are identified in screenings.
- Services in culturally-appropriate locations that can be easily accessed in terms of language, minimal wait times, and transportation.
- Natural/organic family-centered hubs that are built on existing relationships and draw families together around services (co-location of services), like Hope Street's birthing center, WIC, some churches, and sometimes schools.
- Expanded and available services provided in convenient locations, including people's homes and communities.
- Provide services outside of clinics in community- and faith-based settings, such as libraries and churches.
- Services that address global mental health symptoms and are provided in homes, schools, and communities.
- Teen social networking sites that increase social connections and provide educational information.
- Increased funding for schools to build capacity and provide mental health services in the "natural setting" of schools (there is a current shortage of psychiatric social workers/psychologists in schools, as well as a reduction of providers working with the schools).
- Free-standing community clinics located at schools.
- Services in neighborhood hubs, such as schools.
- More programs for at-risk youth in elementary and middle schools as a means of reaching students early to intervene and prevent violence and gang involvement.
- Programs in schools, like DARE for mental health, that are short-term, are presented in a "cool" way, and involve celebrities, parents, and teachers.
- In-home services.
- Increased home services for older adults.
- In-home services that link to other services such as transportation, where to access American Sign Language classes in Spanish, where to take their child who may need mental health intervention.

Specific Strategies and Approaches to Service Delivery

- Proper diagnosis.
- A better system for assessing and diagnosing the mental health needs of young children who are deaf.
- Appropriate screening mechanisms that are more uniform and/or universal -- for children and adolescents, the American Academy of Pediatrics recommends using Bright Futures and PHQ9 to screen for depression and anxiety.
- Developmentally age appropriate assessment tools to diagnose children of teen parents.
- Enhanced responsibility of primary care physicians to properly screen and accurately diagnose mental health issues among older adults.
- Immediate access for initial engagement.
- Early intervention assistance for those with multiple needs, such as the homeless who are deaf.

- Alternative, transformative models of providing PEI services that engage community members.
- New protocol for first-time services.
- Expand and develop new mental health services for all colleges.
- Providers ought to practice "empathy and not sympathy."
- Promotion of holistic senior health.
- Proactive versus reactive interventions for older adults.
- A step-by-step guide to help youth enter adulthood with educational and career pathways, especially youth who may have strikes, and/or may have social or emotional challenges.
- More focus on extracurricular activities and sports as outlets and modes of connecting to other individuals.
- Expansion of county court care programs.

Services and Resources that Increase Access

- Services for uninsured individuals, as they currently have very limited access to services and resources.
- Improved access to mental health services by students, such as satellite sites and peer counseling and referral programs.

> ***"We need to have user-friendly services at any clinic that can give you services and refer you -- that can assist you with whatever you need."***

- Free mental health care services.
- Low-/no-cost programs, services, and support for families with disabilities.
- Affordable or free, user-friendly services for mental health issues before they escalate to the point of crisis.
- Revised and flexible eligibility criteria.
- Ability to bill for ancillary support services provided to the whole family (with which there will inevitably be interaction) when treating the child.
- Bilingual services, particularly in Spanish.
- Appropriate language and cultural expertise.
- Services provided in multiple languages.
- Interpreters for deaf seniors who are accessing hospital services.

Funding and Resources

- Funding for services.
- Funding to integrate mental health into a comprehensive behavioral health care model.
- Resources and/or funding for early intervention programs in community clinics that provide more screenings, train primary care doctors on mental health issues and screening instruments, and hire more LCSW's and other degreed professionals to provide care to more consumers before they have a major disorder.

> ***"The issue for us is funding, and we need to make good referrals for the people who are mostly Hispanic and don't have insurance, or have lost their insurance and they cannot go back with it for some reason. We really don't have a place for them so it's very sad."***

Collaboration, Partnerships, Teams

- Collaboration between schools, CBOs, and law enforcement.
- Collaborative network development efforts by communities, schools, law enforcement, and medical facilities.
- Strengthen networks by encouraging collaboration among faith-based organizations, law enforcement agencies, schools, and community-based organizations.
- Interagency collaborations between DMH, DCFS, and DPSS.

Service Integration and Continuity of Care

- Integrated mental health services.
- Integration of primary health care with behavioral health care (i.e., change "mental health" label to "behavioral health" and address it alongside health care).
- Integrated mental health service delivery across county departments (DMH, LACOE, DCFS) to ensure mental health needs will be met.
- Incorporation of mental health counseling with academic counseling services.
- Coordinate services between schools, families, and multiple sectors.
- More continuity of care with clients who do not show up for appointments.
- Countywide continuum of care programs.

Other

- Effective referral process that will require dedicated staff to refer people to new and existing programs.
- Increased capacity for case management.
- Provide "tools of engagement" or rules for engaging community members in services.
- Fewer restrictions on current mental health so that they can offer more services to the community.
- Encouraging the development of networks of support.
- High level professional system navigators who have undergone significant in-house staff development.

Priority Early Intervention Services/Resources (Q6b)

When the 17 focus groups were asked to prioritize the needed early intervention services cited above, 10 of the 17 participated in the prioritization process, as shown in **Table 7**. Five focus groups did not have the opportunity to prioritize; and, one group elected not to prioritize because they felt all of the early intervention needs they had cited were important. Please note that the priorities listed in **Table 7** are not listed in rank order.

The early intervention priorities identified by 10 of the 17 groups reflect early intervention services and/or resources that would:

- Provide funding for expansion of existing and development of new mental health services at college campuses, in schools, and in communities.
- Offer comprehensive and/or mandated theory-based training for providers, as well as, physicians, hospitals, emergency room staff, and clinicians about mental health symptoms and therapies, in general. At the same time, also train these professionals about how best to support underserved cultural populations, such as the deaf and blind, ethnic and cultural groups, among others.

- Identify and recruit licensed, certified, degreed, and qualified professionals to meet the needs of the community, in particular, interpreters for the deaf and blind community.
- Impress upon primary care physicians the responsibility they have to properly screen and accurately diagnose mental health issues among older adults.
- Develop an effective referral process that is run by dedicated staff.
- Integrate health and mental health care, in general, but also by implementing one-stop centers in which all primary care and all mental health needs are met, or by incorporating mental health counseling with academic counseling in schools, for example.
- Establish services in convenient and accessible locations, such as family-centered services or organic family-centered hubs.
- Guide youth, especially emancipated foster youth, to enter adulthood with educational and career goals through mentors and counselors who can relate to youth experiences, serve as role models, and help them set goals and manage them.
- Conduct outreach and education to raise awareness about mental health, as well as to educate consumers on how to recognize the signs and symptoms of mental illness, and how to locate and access available services.

Table 7: Priority Early Intervention Services/Resources (n=10)*

Focus Group	Priority 1	Priority 2	Priority 3
Asian Pacific Policy and Planning Consortium	No Response.	No Response.	No Response.
CSU Long Beach - Suicide Prevention and Intervention Team	No Response.	No Response.	No Response.
Community Clinic Association of Los Angeles County	Additional funding for existing school- and community-based programs.	Comprehensive integrated health and mental health care.	One-stop centers in which all primary care and mental health needs are met.
DCFS - Transitional Housing Program	No Response.	No Response.	No Response.
GLAD	Licensed, certified, degreed, and qualified professionals to meet the mental health needs of the deaf and blind community.	Paid interpreters for the deaf and blind at hospitals, medical offices, and service provider locations, including multi-lingual interpreters to service those who do not speak English or use American Sign Language.	Mandated training for physicians, hospital and emergency room staff, and clinicians about the deaf and how to support and service their needs.
ICARE Network	Comprehensive knowledge and theory-based training for providers.	Family-centered services (therapy/organic family-centered hubs).	No Response.
LA Coalition of School Health Centers	Increased funding for school-based programs to	Funding so that community providers can offer both	More services to meet the needs of many non-

Focus Group	Priority 1	Priority 2	Priority 3
	build capacity and expand mental health services.	school- and community-based services.	English speaking, uninsured individuals in the community.
Los Angeles Community College District	Expansion of existing and development of new mental health services for all colleges.	Development of an effective referral process with dedicated staff.	Incorporation of mental health counseling with academic counseling services.
LA County Commission for Children and Families	All listed are important and interrelated.	All listed are important and interrelated.	All listed are important and interrelated.
LA County Mental Health Commission	Expansion and funding of existing services.	No Response.	No Response.
LACDMH Children's Outpatient Programs	No Response.	No Response.	No Response.
LACDMH Psychiatric Mobile Response Team	Individual mental health counseling.	Services/programs that address global mental health symptoms.	No Response.
National Alliance on Mental Illness	No Response.	No Response.	No Response.
TAY Residents of Dorothy Kirby Center	Mentors and counselors who can relate to youth and their experiences.	Mentors and counselors who help youth self-manage and set goals, and serve as role models.	Step-by-step guide to help youth enter adulthood with educational and career pathways, especially for those youth who have social and/or emotional challenges.
Older Adult System of Care	Enhanced responsibility of primary care physicians to properly screen and accurately diagnose mental health issues among older adults.	Increased home outreach services.	Increased education and awareness about mental health among older adults.
United American Indian Involvement	No Response.	No Response.	No Response.
US Veterans, Inc. – Double Trudgers	Effective education and outreach activities about available services.	Training on how to recognize the signs and symptoms of mental illness.	Expanded and available services provided in convenient locations.

*Six focus groups did not have an opportunity to identify early intervention priorities; one group indicated that all the listed early intervention needs were interrelated and equally important.
Note: Priorities are not listed in rank order.

Locations for Early Intervention Services/Resources (Q6c)

Table 8 presents the locations at which focus groups would like to see early intervention services offered. Among 17 focus groups, 11 provided locations.

The participants of the 11 responding focus groups recommended similar locations to those listed for prevention services. Among the prevention locations listed in **Table 6** in a prior section of this report, four of the top five locations also appear among the top five early intervention locations identified by focus group participants and listed in **Table 8** below: schools, community agencies and centers, faith-based organizations and easily accessible, centrally located, and inviting, comfortable places. The only difference among the top five locations in the two tables is that more focus groups considered

homes a priority early intervention location than a prevention location. The top five locations listed in **Table 8** are followed by locations only cited once. A breakdown of locations by focus group is provided in **Table 8A** in **Appendix B**.

"We need to provide services outside of the clinic because that's what will help with the stigma. So if we hold it in a community, church place, or if we hold something in a library, in a group room in a library, people are much more likely to come."

Table 8: Early Intervention Service Locations

Early Intervention Service Locations	Number of Groups (n=11)*
Schools	**7**
Community Agencies/Centers	**4**
Faith-based organizations (i.e., churches)	**4**
Homes	**3**
Easily accessible, centrally located, and inviting/comfortable places	**2**
Beauty Salons	**1**
Community Health Centers/Clinics	**1**
Community Colleges	**1**
Department of Motor Vehicles	**1**
Hospitals/Emergency Rooms	**1**
Laundromats	**1**
Neighborhood hubs (i.e., schools)	**1**
Other Agencies	**1**
Parks and Recreational Centers	**1**
Primary Care Physician Offices	**1**
Residential Care Facilities	**1**
Senior Centers	**1**
WIC	**1**

* Six focus groups did not provide preferred locations for early intervention services.

VIII. Barriers to Service Access and Strategies to Increase Access

Barriers to Service Access (Q7)

Focus group participants were asked "What keeps people from getting the prevention and/or early intervention services they need?" In response, the Countywide focus group participants predominantly discussed various barriers to access, with an emphasis on stigma and discrimination, cost and eligibility criteria, and the linguistic and cultural competency of services, as shown in **Table 9**. A breakdown by focus group is provided in **Table 9A** in **Appendix B**.

"And if you mentioned anything about mental health, use those words with an older adult and they'll say, 'I don't need that, I'm not crazy.'"

With respect to stigma and discrimination, participants cited various forms of stigma. One focus group noted that age-specific stigma is evident in the mental health messaging for older adults, which makes inaccurate associations between older adults and mental health issues. Another focus group discussed how stigma is derived from the evident lack of public acceptance for people who have mental health needs. Others talked about the general fear of gossip and discrimination, shame, embarrassment, and social judgment that spawn resistance to seeking services. One focus group duly noted that as a result of the stigma surrounding mental health, people develop a lack of trust in the system, and turn to nontraditional delivery systems that in some cases may not appropriately diagnose or address their presenting mental health issues.

Costs and eligibility criteria were almost as highly-mentioned as stigma and discrimination, and represent another persistent barrier to service access. In this area, focus group participants discussed the inability of individuals and families to pay for services, the high number of uninsured who do not have access to services, the bureaucratic red-tape and paperwork required to gain access, and the inability to qualify without fitting into certain Medicare, Medi-Cal, or insurance-driven diagnostic categories or quota-based service slots.

"Undocumented families are afraid to access mental health services for fear of deportation."

Aside from the challenges consumers face paying for services and meeting service requirements, the language and cultural barriers that exist between consumers and providers, coupled with the lack of available services, becomes a double-edged barrier to access. Focus group participants commented that mental health services lack the staff who can understand the acculturation issues and struggles of immigrant and non-immigrant families who speak a language other than English and represent different cultures. Certain focus groups brought to light that the language and cultural barriers are not only limited to ethnic populations, but extend beyond to other underserved cultural groups, such as the deaf and blind, homeless, and others. While services may lack linguistic and cultural specificity, consumers' circumstances become exacerbated when the services are non-existent, limited, or are confined to specific services, such as medication management, screenings, counseling, etc. Further complicating matters, services that are available are not always conveniently located. Other issues mentioned included: limited service hours, long wait lists, unfriendly front-line staff, and a lack of high quality services.

Other critical barriers to service access are lack of the following: knowledge and awareness about mental health in general; which services are available; parent training on how to identify the early signs and symptoms of developmental and behavioral issues in their children; linguistically- and culturally-appropriate messaging and available materials, and awareness of the mental health needs of underserved cultural populations. A few focus groups offered examples that reflect these challenges. One focus group participant stated that she had been involved with United American Indian Involvement for two years and just recently learned they offer therapy. Another focus group indicated that parents do not have the parenting skills they need to recognize the early concerns about their children's behavior and how to address and cope with them. Another pointed out that mental health service information is not consumer-friendly and the messages about mental health are not culturally- and linguistically-engaging or appropriate. Lastly, one focus group representing the deaf and blind felt a lack of sensitivity toward and awareness of the mental health needs of different underserved cultural populations and how to address them.

Among the 17 countywide focus groups, some commented on the challenges providers face trying to engage children and families who are either in denial or simply do not want to access services. Some participants reported that many parents do not want to add one more thing to their already full plate.

Others talked about individuals who do not acknowledge their issues and do not want to change. Yet, others indicated that some, particularly those who have been diagnosed, withdraw from service engagement as they withdraw from other people in their life. With respect to engaging children in services, one focus group also stated that "not everyone is committed to helping their children."

Other barriers that arose from the focus groups discussions included:

- Lack of funding and resources to meet the mental health needs in communities
- The high rate of misdiagnosed consumers and the negative impact on consumers and communities of being improperly and/or inappropriately diagnosed and over-medicated.
- Immigration or legal status of individuals who need services.
- Non-existent or no training among providers and their staff in service delivery, customer service, and culturally-appropriate services.
- Poor follow-through with referrals to verify that people access the services to which they have been referred.
- Inflexibility of the DMH system to accept private insurance, make interpreters available, or serve children, parents, and families who do not meet the diagnostic criteria for service.
- Too few advocates for children ages 0 to 5, and limited assistance for individuals who are returning to their communities after having been incarcerated.
- Unwillingness to diagnose or address symptoms until they get worse.
- Lack of centrally-located, home-based, field-based, or on-campus services
- Over-medication and its side effects.
- Unfair and insensitive expectations of consumers.
- Poverty and other economic barriers preventing people from accessing services.
- Lack of hospital emergency beds and in-patient care.
- Lack of communication among service providers.
- Limited involvement of community advocates
- Inadequate referral system to mental health providers.
- School teachers and counselors lack awareness and understanding of children's hearing loss, and how to differentiate between a child with behavioral issues and a child with hearing loss.
- Low self-esteem of parents keeps them from addressing their mental health needs.
- Lack of recognition of those youth who are doing well.

Table 9: Barriers to Service Access

Access Barriers	Number of Mentions
Access Issues	**82**
• Stigma and Discrimination	22
• Cost/Insurance/Medi-Cal/Eligibility Criteria	19
• Service Linguistic/Cultural Competency	12
• Available Services/Capacity	8
• Service Operations	8
• Geographic Location/social and Physical Conditions/Transportation	7
• General	3
• Trust	3
Outreach/Education/Awareness	**14**
• Available Services	6
• Families/Parents	2
• General	2
• Messaging	2
• Linguistic/Cultural Appropriate Messaging	1
• Target Populations	1
Service Engagement/Benefits	**8**
• General	5
• Families/Parents	3
Funding and Resources	**5**
Service Quality	**5**
Immigration/Cultural Matters	**4**
Staff/Provider Education/Training/Recruiting	**4**
Service Integration/Continuity of Care	**3**
Service Restrictions-Legal/Bureaucratic	**3**
Systems Support/Assistance/Navigators	**3**
Unaddressed/Exacerbated Mental Health Conditions/Higher Levels of Care/Poor Social Conditions	**3**
Assessment/Identification/Intervention-Early Better Outcomes	**2**
Location-based Services	**2**
Medication Issues/Management	**2**
Sensitive Staff/Can Relate	**2**
Social/Economic Conditions	**2**
Available Services-Other than MH	**1**
Collaboration/Partnerships/Teams	**1**
Community/Client Involvement in MH Process	**1**
MH Issues	**1**
Referral Network	**1**
School Issues	**1**
Self-Care/Self-esteem/Socialization	**1**
Specific Services (Various)	**1**
Specific Strategies/Approaches	**1**
Other	**6**

Strategies to Increase Access (Q8)

As a follow-up to the question about service barriers, focus group participants were asked to discuss the types of strategies that would help people obtain access to the services they needed (see **Table 10**). One focus group did not have an opportunity to respond to this question. A breakdown by focus group is provided in **Table 10A** in **Appendix B**.

Outreach, education, and awareness arose as a predominant strategy for improving access. Focus group participants discussed ways of conveying information about available services, where to conduct outreach efforts, the importance of using linguistically- and culturally-appropriate messaging, populations to target, and education for parents and families. Specific outreach and educational mediums proposed to increase community members comfort level with mental health included print media, radio, educational videos, the internet, word-of-mouth, and the Promotoras model. Focus group participants stated that the messages conveyed through these media ought to be in multiple languages, age- and ethnically-appropriate, and replace traditional messaging by promoting wellness and a strength-based approach to mental health. In addition, a couple of focus groups recommended either raising awareness about the 2-1-1 system, which currently connects people to a number of community services, or developing and promoting a common database of available services and where they are located.

Another major strategy for increasing access cited by participants across focus groups is bringing services directly into communities where the children and families work, live, and play. A variety of locations were suggested including the following:

- College Campuses;
- Community Centers;
- Day Care Centers;
- Faith-based Organizations;
- Hospitals;
- In-home Services;
- Mobile Vans;
- One-stop Centers offering multiple services (food stamps, health care, mental health, social services, etc.) and extended hours;
- Recreation Centers;
- School-based Health Clinics; and,
- WIC Program Sites;

According to participants, many of these locations represent either easily accessible locations close to home, school or work; friendly places where people are comfortable accessing services; and even places where people can connect with others the same age.

"The lack of transportation and geographic distance keeps people from accessing needed services."

Strategies to reduce access barriers were also discussed. Focus group participants talked about multiple ways in which access to services could be improved. First and foremost, they advocated for service environments that are warm, friendly, and welcoming; offer child care and transportation services; and have hours that accommodate working class families. In addition, they voiced the importance of recruiting and hiring culturally- and linguistically-competent staff who are sensitive to and can relate to the mental health issues of community members.

Several focus groups mentioned specific services, including counseling and therapy, as another means of increasing access. These services covered a broad spectrum of needs. For example, one focus group recommended peer-to-peer programs as a means of drawing veterans from Iraq and Afghanistan to seek assistance. Another suggested providing telephone cards to those who do not have access to telephones in order to make services more available to them. Screenings for prodromal symptoms as part of routine check-ups and immunizations was mentioned as another approach to service engagement and, simultaneously, prevention. The focus group conducted with the deaf, hard–of-hearing, and blind recommended hotlines that link deaf and blind individuals to direct services that provide interpreters. And lastly, more easily-accessible and available mentoring services for parents and families.

Dovetailing with specific services, focus group participants also presented different strategies that promote access. For example, one focus group interested in the well-being of young children suggested establishing a strong provider network to provide timely referrals and care for very young children. Another focus group advocated for "forgiveness" programs for people who have been engaged in services so that they do not have to face the same barriers accessing educational and employment opportunities as they face accessing mental health services. Another focus group proposed providing "tools of interest" to communities in need, similar to the provisions provided by the Red Cross, such as water, food, shelter or spiritual counseling.

Taking a more global approach, one focus group urged the system to undertake a transformation of the workforce and increase the number of providers, recruit and hire culturally-competent staff, build effective collaborations, integrate new methods and technologies, and provide training and cross-training. Other participants extended this call to developing competent mental health professionals to developing a long-term plan for working with institutions of higher education to incorporate training about social-emotional development into the program curriculum across the systems of care and fields of study. Participants also saw how training clergy, teachers, and medical personnel, and other non-mental health providers on how to screen for risk-factors in a non-judgmental way might advance access to services.

"Training different people who are non-mental health providers, whether it's ministers or teachers or other people in the community in different settings, so that they can do certain things without necessarily having professional training to help."

From another perspective, some focus groups focused on funding and resources as a means of increasing access. They felt long-term funding would enable them to ensure more comprehensive services, consistent services, and new services. Other strategies for increasing access cited by focus group participants involved the following:

- Identifying at-risk groups to target for early identification through screenings and other tools.
- Building relationships among organizations among community leaders, agencies, service providers, schools, and families.
- Using strategies and approaches that give consumers an opportunity to share and relate to mental health professionals; appreciating cultural differences; and, understanding individual progress.
- Involving family in the delivery of treatment, as well as involving community members and consumers in the design of services and programs.

- Offering incentives to consumers, such as food stamps or other basic needs, for participation in such services as parenting classes or counseling.
- Integrating services, in general, and specifically building capacity among service providers, such as child care providers and physicians, who interact with consumers on a regular basis.
- Providing system supports, such as a system navigator, shelters, community centers, and mentors to those who need assistance accessing services. This might include, but not be limited to, the deaf and blind, individuals released from jail, immigrants, and individuals who speak a foreign language and or are from different cultural backgrounds.
- Using case managers to connect people to services.
- Cultivating a team approach to referrals, particularly in those cases when the individual is presenting multiple issues that may need to be addressed by multiple service sectors (education, law enforcement, health, etc.).
- Helping consumers understand the consequences of not addressing mental health needs earlier rather than later.

"We continually come up with this issue of stigma and the fact that people don't want to access traditional mental health services. If you're talking about a shift for prevention and early intervention, they may still perceive it as a mental health service. So, from the medical standpoint, we would try to build it in to our medical exams and what we do, our screening, and or referral network, and maybe even our guidance and how we counsel people. But that would be the same for any type of program whether it be an educational, a health or a social service program. It will make it more familiar to people so that in some ways they don't even know -- they don't even have to know about the program. They would be accessing by virtue of accessing a service at their regular daily activities ."

Table 10: Strategies to Increase Access*

Strategies to Increase Access	Number of Mentions
Outreach/Education/Awareness	**30**
• Specific Mediums	10
• Available Services	6
• Target Populations	4
• Linguistic/Culturally-appropriate Messaging	3
• Messaging	3
• Specific Locations	2
• Families/Parents	1
• General	1
Location-based Services	**16**
Access Issues	**14**
• Service Operations	6
• Service Linguistic/Cultural Competency	3
• Geographic Location/Social and Physical Conditions/Transportation	2
• Cost/Insurance/Medi-Cal/Eligibility Criteria	1
• Available Services/Capacity	1
• Stigma and Discrimination	1
Specific Services	**10**
• Various	8
• Counseling/Therapy/Groups/Hotlines	2
Funding and Resources	**6**
Specific Strategies/Approaches	**6**
Staff/Provider Education/Training/Recruiting	**6**
Assessment/Identification/Intervention-Early/Better Outcomes	**4**
Collaboration/Partnerships/Teams	**4**
Sensitive Staff/Can Relate	**4**
Community/Client Involvement in MH Process	**3**
Service Engagement/Benefits	**2**
• General	1
• Families/Parents	1
Service Integration/Continuity of Care	**2**
System Support/Assistance/Navigators	**2**
Accountability	**1**
Case Management	**1**
Mental Health Issues-General	**1**
Referral Network	**1**
Service/Treatment Effectiveness/Acceptance/Utilization	**1**
Unaddressed/Exacerbated Mental Health Conditions/Higher Levels of Care/Poor Social Conditions	**1**
Other	**6**

*One focus group did not respond to this question.

IX. Recommendations for Informing Communities about PEI

Recommendations

When focus group participants were asked to provide recommendations on how to let people know about prevention and early intervention services, they focused predominantly on various means of outreach, education, and awareness (see **Table 11**). A breakdown by focus group is provided in **Table 11A** in **Appendix B**.

In particular, ways of conveying information about prevention and early intervention mental health services dominated the discussion, as did the locations at which the information should be distributed. In addition, participants talked about outreach and education in general terms, noting languages in which campaigns should be conducted, the way mental health is communicated, the populations that should be targeted, what types of education and training parents and families should receive, and where and how to identify and connect with available services.

About one-half of the mentions around ways of conveying information focused on public service announcements and commercials via billboards, television, radio, public transportation systems, and even movie theater promotional ads. The proportion of mentions promoting print versus Internet versus word-of-mouth as means of communicating about prevention and early intervention were equally distributed.

Print media recommendations included flyers and brochures in multiple languages, as well as communicating through posters and bookmarks. Community-based newsletters were also targeted as a means recommended means of providing community members with information about available services and mental health education. Specific newsletters sited were those sponsored by Glendale Clients Helping Clients and Seven Generations.

Focus group participants also thought creatively about how to use electronic media, such as pop-ups or communications via the Internet, in general, to raise awareness about mental health. More specifically, focus groups mentioned text messages, instant messaging, and listserves such as Facebook, Deaf CA, soeasy.com, Yahoo and Yahoo Groups as viable means of reaching large audiences.

Ways of promoting mental health education and services with a personal touch also were discussed. Specific forms of word-of-mouth communication were offered by the focus groups. One focus group suggested involving parent advocates and/or developing “parent partners” as part of parent cafés to encourage the development of support networks. Another advocated for establishing peer-to-peer relationships among older adults as a means of disseminating information in a non-stigmatizing way. Another suggested enlisting community-based organization frontline staff to promote available services and how-to information on maintaining social and emotional well-being. Two additional focus groups supported presentations in general, and “in-reach” through college courses and workshops on health and personal development.

As reflected in the list provided by the focus groups, the locations at which outreach, education, and awareness efforts might be conducted and information displayed and provided is extensive and pervades a wide range of community-centered entities, as reflected in the list below:

- American Association of Retired Persons (AARP).
- Amusement Parks.
- Buses.

- Check Cashing Centers.
- College campuses:
  - At the Student Union;
  - During registration; and,
  - During orientation.
- Community Clinics, Doctors' Offices, and Hospitals:
  - When consumers come in for primary health care and screenings.
- Conventions:
  - Deaf Expo.
- County Buildings:
  - Offices where consumers access economic resources, such as SSI.
- Daycare Centers:
- Faith-based organizations, such as churches.
- Grocery Stores.
- Hair Salons.
- Job Resource Centers.
- Libraries.
- Liquor Stores.
- Malls.
- McDonalds.
- On Every Corner.
- Parent Centers in schools.
- Regional Centers.
- Retail Stores:
  - Target.
- Schools:
  - Head Start.
- Town Hall Meetings.
- WIC.

"We think about going to PTAs, but it might also mean going to Kiwanis Club meetings, Lions Club meetings, just regular community groups …. Boy Scouts, Girl Scouts, quilting groups … or in the school district or any other groups. You make that connection and then go into do some education."

"It should be a budgeted part of the whole Mental Health Services Act and get professional marketing people to take it on. Get the message out there, on television. It think it is critical or we're not going to be able to sustain the momentum that we have right now."

Aside from recommending potential mediums to communicate about prevention and early intervention, focus group participants also recommended general overarching means of educating communities; in particular, broad-based, comprehensive, and aggressive public awareness campaigns were emphasized. Participants also underscored that the presentation should be "cool" and use famous spokespeople affiliated with specific cultural populations, such as the deaf, older adults, veterans, young children, among others, to grab the attention of the communities at large.

As part of any outreach, education, and awareness effort, regardless of the medium, location, or type of campaign, participants emphasized that not only is the content of the message critical, but equally as critical is that the message is communicated in a linguistically- and culturally-appropriate manner.

Three of the 17 focus groups felt that parents and families, seniors, school administrators and teachers, and college students are target populations that should be considered in any outreach efforts.

Other less frequently-mentioned recommendations concerned specific strategies for informing community members about PEI, such as upgrading the Department of Mental Health website to include programs, agencies, and activities for consumers and service providers; integrating mental health into a comprehensive health care approach; creating a contact information card that could be disseminated by law enforcement and the schools; and using social norming strategies, similar to those used in the anti-smoking campaigns, to talk about mental health issues.

A few focus groups also talked about the need for outreach efforts to include providing support from the larger system of public services in the form of mentors, information sharing, and administrative buy-in and leadership. Collaborations and partnerships were also mentioned as means of "getting the word out" and raising awareness of mental health issues in communities, as were in-service and cross-trainings among service providers.

Lastly, one focus group recommended that services be accountable by publicly disseminating information about how the PEI funds are being spent. Another advocated for allowing community-based organizations to develop effective outreach strategies specific to their communities. Others suggested channeling money into communities, providing PEI services in non-clinical settings, and integrating mental and health care services; thus, sending the message that mental health care is one aspect of our social, emotional, and physical well-being.

Table 11: Recommendations for Informing Communities about PEI

Recommendations	Number of Mentions
Outreach/Education/Awareness	**125**
• Specific Mediums	56
• Specific Locations	39
• General	11
• Linguistic/Culturally-appropriate Messaging	7
• Messaging	5
• Target Populations	3
• Families/Parents	3
• Available Services	1
Specific Strategies/Approaches	**4**
System Support/Assistance/Navigators	**3**
Collaboration/Partnerships/Teams	**2**
Staff/Provider Education/Training/Recruiting	**2**
Access Issues-Geographic Locations	**1**
Accountability	**1**
Community/Client Involvement in MH Process	**1**
Funding and Resources	**1**
Location-based Services	**1**
Service Integration/Continuity of Care	**1**
Other	**6**

X. Summary

The 17 Countywide focus groups represented a diverse array of age groups, sectors, mental health needs, and priority populations across all eight of the Los Angeles County Service Areas. Among a total of 159 participants, approximately half reported knowledge of and experience with the PEI planning process through a variety of avenues including, as MHSA Stakeholder Delegates, local committee chair or co-chairs, or members of committees and commissions; and, as attendees of SAAC meetings, service area planning meetings, DMH meetings and other agency-specific informational meetings.

When asked to select the priority populations they represent, the majority of participants considered all the priority populations important, resulting in one percentage point differences among the top four priorities selected. Children and youth in stressed families and Trauma-exposed were tied for the top priority, representing 76 percent of the participants each. Underserved cultural populations and Individuals experiencing the onset of a serious psychiatric illness were the second and third priorities, representing 75 and 74 percent of participants, respectively. With respect to mental health needs, approximately 8 in 10 participants identified Disparities in access to mental health services as a top mental health need, followed by Suicide Risk (77%), At-risk children, youth, and young adult populations (77%), Psycho-social impact of trauma (76%), and Stigma and discrimination (74%). However, when asked to prioritize the mental health needs, Disparities in access to mental health services remained a top priority, and At-risk children, youth, and young adult populations as a second priority, with Psycho-social impact of trauma replacing suicide risk as a third priority.

The discussion concerning the impact of mental health needs on the community revealed a wide array of issues with which communities countywide are grappling. The five most highly-mentioned impacts concerned: 1) access to mental health services; 2) the increasing number of mental health issues among community members; 3) the pervasiveness of community and family violence and abuse; 4) the social and economic conditions under which community members live; and, 5) the declining quality of services received.

Needed priority prevention and early intervention services reflected strategies and approaches for addressing the impacts discussed previously. As examples, one prevention service priority seeks to expand and integrate existing school-based services, communication systems among service sectors, school health and community clinics, and culturally-appropriate services. Another prevention service priority focuses on engaging parents and families in designing and implementing effective service strategies and family-centered approaches, and a third priority identified advocates for establishing one-stop comprehensive services, Clubhouse/Wellness Centers, and recreational opportunities for community members.

Similarly, needed priority early intervention services also reflected strategies and approaches to overcoming the community impacts identified by participants. One early prevention priority service centers on offering comprehensive and/or mandated theory-based training for providers, as well as physicians, hospitals, emergency room staff, and clinicians about mental health symptoms and therapies; while another service priority is to establish services in convenient and accessible locations, such as family-centered services or organic family-centered hubs.

Critical barriers to service access identified by focus group participants included access-related issues such as stigma and discrimination, as well as the lack of outreach, education, and awareness efforts to promote mental health and teach community members how to recognize signs and symptoms. Consequently, outreach, education, and awareness arose as a predominant strategy for improving access, as did bringing services directly into communities where children and families work, live, and

play. Similarly, focus group participants also focused on outreach, education, and awareness as a key means of informing communities about prevention and early intervention mental health services.

> ***"Some of our clients and patients come in with their mail because they don't speak English. They ask, 'Is this important?' We have to help them open their mail and just go through very daily things like that. So if the message comes from us … I think we're the trusted source."***

APPENDIX A

APPENDIX A: Focus Group Guide

FOCUS GROUP QUESTIONS

Issues	Focus Group Questions
PEI Planning Process	1. Have you or your group taken part in the Los Angeles County Department of Mental Health's (DMH) Prevention and Early Intervention (PEI) planning process? If so, how?
Participants' Organizational Affiliation	These focus groups help us learn more about the types of mental health services and resources that are needed to support the social and emotional well-being in your community and among other groups of people in L.A. County. 2. Which region or area in L.A. County do you represent or will you be talking about in today's discussion? 2a. Of the identified priority populations [*facilitator refers/points to visual aid listing priority populations*], which of these groups of people do you represent?
Community Mental Health Needs	The California State Department of Mental Health said that the Prevention and Early Intervention (PEI) plan should focus on the needs of the following groups: at-risk youth, people who may be at risk of suicide, people who haven't been able to get services, and people who have experienced trauma, stigma and discrimination. 3. What needs are most important to the group of people you represent? *3a. Of the needs that you've listed, which are the top three needs most important to your community?* 4. What do you see happening in your community because of these needs? (what problems are occurring?)
Prevention and Early Intervention Services	As we talked about earlier, there is a difference between prevention and early intervention services [*facilitator refers/points to visual aid defining prevention and early intervention*]. 5. What **prevention** services or resources are currently available in your community or among the group of people you represent? 5a. What **prevention** services or resources are needed? 5b. "O*f the prevention services you've listed, which are the top three needed*. 5c. *Facilitator probes for information on locations for services.*

APPENDIX A: Focus Group Guide

Issues	Focus Group Questions
	6. What **early intervention** services or resources are currently available in your community or among the group of people you represent? 6a. What **early intervention** services or resources are needed? 6b. *Of the early intervention services you've listed, which are the top three needed in your community?* 6c. F*acilitator probes for information on locations for services.* 7. What keeps people from getting the prevention and/or early intervention services they need? 8. What types of things or strategies would help people get the services they need?
Long Range Planning	9. What recommendations do you have for how to let people know about prevention and early intervention services?

APPENDIX B

Focus Group ID Key

To create user-friendly and readable data tables of the findings by focus group, each focus group has been assigned an ID number that will be used to identify the data representing participant responses to the questions posed during the focus group. The focus group name and corresponding ID number are listed below.

ID	Focus Group Name
1	Los Angeles County Older Adult System of Care (OASOC)
3	California State University, Long Beach - Suicide Prevention and Intervention Team
6	Los Angeles Coalition of School Health Centers
7	Community Clinic Association of Los Angeles County (CCALAC)
8	Department of Children and Family Services - Transitional Housing Program
12	ICARE Network (pre-natal to five focus)
13	United States Veterans, Inc. - Double Trudgers
14	Asian Pacific Policy and Planning Consortium (A3PCON)
17	Los Angeles County Probation Department - Transition-age Youth (TAY) Residents of Dorothy Kirby Center
23	Los Angeles County Commission for Children and Families
28	Los Angeles County Mental Health Commission
33	Los Angeles Community College District (LACCD)
34	Greater Los Angeles Agency on Deafness, Inc. (GLAD)
41	Los Angeles County Department of Mental Health - Children's Outpatient Programs
50	United American Indian Involvement (UAII)
56	Los Angeles County Department of Mental Health - Psychiatric Mobile Response Team
62	National Alliance on Mental Illness (NAMI)

APPENDIX B: Selected Data Tables by Focus Group

Table 1A: PEI Priority Populations by Focus Group

		Number of Mentions by Focus Group																
PEI Priority Populations	**CW n=159**	**1 n=8**	**3 n=5**	**6 n=9**	**7 n=11**	**8 n=14**	**12 n=11**	**13 n=8**	**14 n=11**	**17 n=10**	**23 n=10**	**28 n=10**	**33 n=8**	**34 n=9**	**41 n=10**	**50 n=8**	**56 n=10**	**62 n=7**
Children/Youth in Stressed Families	**121**	0	5	9	10	7	9	3	11	9	10	4	7	2	10	8	10	7
Trauma-exposed	**121**	8	5	9	11	1	8	6	11	7	10	5	7	3	9	4	10	7
Underserved Cultural Populations	**120**	8	5	8	11	0	8	0	11	6	10	5	8	8	10	5	10	7
Individuals Experiencing Onset of Serious Psychiatric Illness	**118**	8	5	9	11	5	6	5	11	2	10	7	8	2	9	3	10	7
Children/Youth at Risk of or Experiencing Juvenile Justice Involvement	**112**	0	5	8	10	4	7	0	11	10	10	5	6	2	10	7	10	7
Children/Youth at Risk of School Failure	**110**	0	5	9	10	2	10	0	11	5	10	4	8	2	9	8	10	7

APPENDIX B: Selected Data Tables by Focus Group

Table 2A: PEI Mental Health Needs by Focus Group

		Number of Mentions by Focus Group																
PEI Mental Health Needs	**CW n=159**	**1 n=8**	**3 n=5**	**6 n=9**	**7 n=11**	**8 n=14**	**12 n=11**	**13 n=8**	**14 n=11**	**17 n=10**	**23 n=10**	**28 n=10**	**33 n=8**	**34 n=9**	**41 n=10**	**50 n=8**	**56 n=10**	**62 n=7**
Disparities in Access to Mental Health Services	**130**	8	5	9	11	0	11	4	4	10	7	8	9	10	6	10	7	11
Suicide Risk	**123**	8	5	9	11	9	3	5	11	10	1	5	8	9	7	5	10	7
At-risk Children, Youth, and Young Adult Populations	**122**	0	9	11	10	0	2	9	10	7	6	9	9	7	10	7	5	11
Psycho-social Impact of Trauma	**121**	8	5	9	11	0	9	3	11	4	8	5	8	9	10	4	10	7
Stigma and Discrimination	**117**	8	5	9	11	6	9	3	11	0	2	5	8	9	8	6	10	7

APPENDIX B: Selected Data Tables by Focus Group

Table 3A: Priority PEI Mental Health Needs by Focus Group

		Number of Mentions by Focus Group*																
Priority PEI Mental Health Needs	**CW**	**1**	**3**	**6**	**7**	**8**	**12**	**13**	**14**	**17**	**23**	**28**	**33**	**34**	**41**	**50**	**56**	**62**
Disparities in Access to Mental Health Services	**x**	x		x	x		x	x	x	x	x	x	x		x	x		
At-risk Children, Youth, and Young Adult Populations	**x**		x	x		x	x		x	x	x	x			x	x	x	
Psycho-social Impact of Trauma	**x**	x					x				x	x	x		x	x	x	
Stigma and Discrimination		x	x	x	x	x		x	x									
Suicide Risk			x			x		x		x			x				x	

*Focus groups 34 and 62 elected not to prioritize because they felt that all the mental health needs were important and interrelated.

APPENDIX B: Selected Data Tables by Focus Group

Table 4A: Ways in which Mental Health Needs Impact the Community

		Number of Mentions by Focus Group																
Community Impact	**CW**	**1**	**3**	**6**	**7**	**8**	**12**	**13**	**14**	**17**	**23**	**28**	**33**	**34**	**41**	**50**	**56**	**62**
Access Issues	**55**	**4**	**2**	**0**	**2**	**1**	**10**	**5**	**7**	**0**	**4**	**2**	**2**	**9**	**2**	**3**	**2**	**0**
• Stigma and Discrimination	14	3	1			1	2	3	1			1			1		1	
• Available Services/Capacity	13	1			2		1				2		1	5		1		
• Service Linguistic/Cultural Competency	8						2		3		1			2				
• Cost/Insurance/Medi-Cal/Eligibility Criteria	6						2		1					1		1	1	
• General	5		1				2				1	1						
• Geographic Location/Social & Physical Conditions/Transportation	5							2	1					1		1		
• Service Operations	4						1		1				1		1			
Mental Health Issues	**23**	**2**	**2**	**1**	**1**	**3**	**2**	**1**	**0**	**1**	**3**	**1**	**0**	**0**	**1**	**1**	**2**	**2**
• Substance Abuse	7	1		1		1		1		1							1	1
• Depression/Suicide Risk	9		1			2	1				1	1				1	1	1
• Trauma/PTSD/Anxiety	4	1	1								2							
• General	3				1		1								1			
Community/Family Violence/Abuse	**21**	2		2		4	1	2	1	2	1		1			4	1	
Social/Economic Conditions	**19**	1		2	1	3	1	3	1		1		1		1	2	1	1
Service Quality	**17**						11							3	3			
Community/Family Breakdown/Hopelessness	**14**			3	1	3		1	1	2	1						2	
Unaddressed/Exacerbated Mental Health Conditions/Higher Levels of Care/Poor Social Conditions	**10**										5	2			2		1	
Outreach/Education/Awareness	9	1	0	0	0	1	2	1	0	1	1	0	0	1	0	0	1	0
• General	5	1				1	1				1			1				
• Families/Parents	4						1	1		1							1	
Academic Outcomes	**8**			1		1					1	2	1			1	1	
Behavioral/Social/Emotional Issues/Outcomes	**8**		1				2			1	1		1			2		
Families/Parent High Stress	**7**						3						1		2		1	

APPENDIX B: Selected Data Tables by Focus Group

		Number of Mentions by Focus Group																
Community Impact	**CW**	**1**	**3**	**6**	**7**	**8**	**12**	**13**	**14**	**17**	**23**	**28**	**33**	**34**	**41**	**50**	**56**	**62**
Levels/Parenting Issues/Poor Social Skills/Coping																		
Service Integration/Continuity of Care	**6**						3				1	1			1			
Negative/Risky Behaviors	**5**			1	1	2		1										
Overburdened System-Law Enforcement, Schools, DMH, etc.	**5**				1							3			1			
Juvenile Justice Involvement/Incarceration	**4**					1				2							1	
Insufficient Number of MH Staff	**4**		2		1									1				
Support System	**4**		2				2											
Service Engagement/Benefits	**3**						2										1	
Health Care Issues	**3**	2		1														
Immigration/Cultural Matters	**3**						1		1							1		
System Support/Assistance/Navigators	**3**					2				1								
Sensitive Staff/Can Relate	**2**													2				
Assessment/Identification/Intervention-Early/Better Outcomes	**1**										1							
Child Welfare/Foster Care	**1**					1												
Critical Developmental Period	**1**						1											
Medication Issues/Management	**1**										1							
Referral Network	**1**	1																
Self-Care/Self-esteem/Socialization	**1**															1		
Service/Treatment Effectiveness/Acceptance/Utilization	**1**						1											
Traditional/Risk Orientation	**1**						1											
Other	**11**		2			3	1	1	1		1					2		

APPENDIX B: Data Tables by Focus Group

Table 6A: Prevention Service Locations by Focus Group

		Number of Mentions by Focus Group																
Prevention Service Locations	**CW**	**1**	**3**	**6**	**7**	**8**	**12**	**13**	**14**	**17**	**23**	**28**	**33**	**34**	**41**	**50**	**56**	**62**
Schools	**6**			1	1				1		1	1					1	
Community Agencies, Centers, Organizations (i.e., children's agencies)	**5**				1				1		1	1					1	
Easily accessible, centrally located, and inviting, comfortable places	**3**				1					1						1		
Faith-based Organizations	**3**	1							1		1							
Parks and Recreational Centers	**2**	1							1									
Senior Centers	**2**	1							1									
Beauty Parlors	**1**	1																
Community Colleges	**1**												1					
Community Health Centers, Clinics, Medical Centers	**1**								1									
Department of Motor Vehicles	**1**	1																
Early Childcare and Education Sites	**1**						1											
Family Resource Centers	**1**						1											
GLAD	**1**													1				
Homes	**1**	1																
Hospitals	**1**											1						
Jails	**1**											1						
Laundromats	**1**	1																
Law Offices	**1**											1						
Non-traditional, Non-service Public Spaces	**1**	1																
One-stop Comprehensive Services	**1**													1				
Primary Care Physician's Office	**1**	1																
Regional Centers	**1**													1				
Residential Care Facilities	**1**	1																
Youth Centers	**1**								1									
Where the Need is	**1**																	1

APPENDIX B: Data Tables by Focus Group

Table 8A: Early Intervention Service Locations by Focus Group

		Number of Mentions by Focus Group																
Early Intervention Service Locations	**CW**	**1**	**3**	**6**	**7**	**8**	**12**	**13**	**14**	**17**	**23**	**28**	**33**	**34**	**41**	**50**	**56**	**62**
Schools	**7**			1	1		1				1	1		1			1	
Community Agencies/Centers	**4**			1			1				1						1	
Faith-based Organizations (i.e., churches)	**4**	1					1				1						1	
Homes	**3**	1												1			1	
Easily accessible, centrally located, and inviting, comfortable places	**2**									1		1						
Beauty Salons	**1**	1																
Community Health Centers/Clinics	**1**				1													
Community Colleges	**1**												1					
Department of Motor Vehicles	**1**	1																
Hospitals/Emergency Rooms	**1**													1				
Laundromats	**1**	1																
Neighborhood Hubs (i.e., schools)	**1**					1												
Other Agencies	**1**											1						
Parks and Recreational Centers	**1**	1																
Primary Care Physician Offices	**1**	1																
Residential Care Facilities	**1**	1																
Senior Centers	**1**	1																
WIC	**1**						1											

APPENDIX B: Data Tables by Focus Group

Table 9A: Barriers to Service Access by Focus Group

		Number of Mentions by Focus Group																
Access Barriers	**CW**	**1**	**3**	**6**	**7**	**8**	**12**	**13**	**14**	**17**	**23**	**28**	**33**	**34**	**41**	**50**	**56**	**62**
Access Issues	**82**	**5**	**4**	**4**	**3**	**3**	**5**	**3**	**6**	**2**	**5**	**6**	**5**	**9**	**2**	**9**	**7**	**4**
• Stigma and Discrimination	22	1	2	1	1	2	1	1	1	1	1	1	1	1		4	1	2
• Cost/Insurance/Medi-Cal/Eligibility Criteria	19	1	1		1		2	2	2	1	1	1	2	2		1	2	
• Service Linguistic/Cultural Competency	12	1		1	1		1		2		3			1	1		1	
• Available Services/Capacity	8	2		1								1	2	1			1	
• Service Operations	8						1		1			2		1		1		2
• Geographic Location/social and Physical Conditions/Transportation	7					1								2	1	2	1	
• General	3		1											1		1		
• Trust	3			1								1					1	
Outreach/Education/Awareness	**14**	**0**	**0**	**0**	**1**	**0**	**2**	**1**	**0**	**1**	**2**	**1**	**1**	**1**	**1**	**1**	**0**	**2**
• Available Services	6						1	1					1		1	1		1
• Families/Parents	2						1			1								
• General	2											1						1
• Messaging	2										2							
• Linguistic/Cultural Appropriate Messaging	1				1													
• Target Populations	1													1				
Service Engagement/Benefits	**8**	**0**	**0**	**0**	**0**	**4**	**0**	**2**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**
• General	5					1		2		1						1		
• Families/Parents	3					3												
Funding and Resources	**5**				1		2						1		1			
Service Quality	**5**	1				1	1						1					1
Immigration/Cultural Matters	**4**						1	1	1		1							
Staff/Provider Education/Training/Recruiting	**4**						1		1					1	1			
Service Integration/Continuity of Care	**3**				1										1			1

APPENDIX B: Data Tables by Focus Group

		Number of Mentions by Focus Group																
Access Barriers	**CW**	**1**	**3**	**6**	**7**	**8**	**12**	**13**	**14**	**17**	**23**	**28**	**33**	**34**	**41**	**50**	**56**	**62**
Service Restrictions-Legal/Bureaucratic	**3**													1	1			1
Systems Support/Assistance/Navigators	**3**						1			1						1		
Unaddressed/Exacerbated Mental Health Conditions/Higher Levels of Care/Poor Social Conditions	**3**					1				1					1			
Assessment/Identification/Intervention-Early Better Outcomes	**2**			1		1												
Location-based Services	**2**	1											1					
Medication Issues/Management	**2**					2												
Sensitive Staff/Can Relate	**2**					1				1								
Social/Economic Conditions	**2**					1							1					
Available Services Other than MH	**1**																	1
Collaboration/Partnerships/Teams	**1**																	1
Community/Client Involvement in MH Process	**1**										1							
Mental Health Issues	**1**												1					
Referral Network	**1**	1																
School Issues	**1**													1				
Self-Care/Self-esteem/Socialization	**1**					1												
Specific Services (Various)	**1**														1			
Specific Strategies/Approaches	**1**									1								
Other	**6**	1				1									2	1		1

APPENDIX B: Data Tables by Focus Group

Table 10A: Strategies to Increase Access

		Number of Mentions by Focus Group																
Strategies	**CW**	**1***	**3**	**6**	**7**	**8**	**12**	**13**	**14**	**17**	**23**	**28**	**33**	**34**	**41**	**50**	**56**	**62**
Outreach/Education/Awareness	**30**	**0**	**1**	**1**	**0**	**4**	**4**	**2**	**4**	**0**	**5**	**0**	**2**	**0**	**0**	**4**	**1**	**2**
• Specific Mediums	10		1			2		1	2		3					1		
• Available Services	6			1		1	2									1		1
• Target Populations	4					1			1				1			1		
• Linguistic/Cultural Appropriate Messaging	3										2						1	
• Messaging	3						1						1					1
• Specific Locations	2							1	1									
• Families/Parents	1															1		
• General	1						1											
Location-based Services	**16**		**3**	**2**	**1**	**1**	**1**	**3**	**3**					**1**		**1**		
Access Issues	**14**	**0**	**2**	**1**	**0**	**2**	**0**	**1**	**3**	**0**	**1**	**0**	**2**	**0**	**0**	**0**	**0**	**2**
• Service Operations	6		1						1		1		2					1
• Service Linguistic/Cultural Competency	3			1					1									1
• Geographic Location/social and Physical Conditions/Transportation	2					1			1									
• Cost/Insurance/Medi-Cal/Eligibility Criteria	1							1										
• Available Services/Capacity	1		1															
• Stigma and Discrimination	1					1												
Specific Services	**10**	**0**	**3**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**2**	**1**	**1**	**0**	**1**
• Various	8		3			1								1	1	1		1
• Counseling/Therapy/Groups Hotlines	2								1					1				
Funding and Resources	**6**			2	1						1		1					1
Specific Strategies/Approaches	**6**		1				1			2					1		1	
Staff/Provider Education/Training/Recruiting	**6**			1			2								1		2	
Assessment/Identification/Intervention-	**4**										1	1					2	

APPENDIX B: Data Tables by Focus Group

		Number of Mentions by Focus Group																
Strategies	**CW**	**1***	**3**	**6**	**7**	**8**	**12**	**13**	**14**	**17**	**23**	**28**	**33**	**34**	**41**	**50**	**56**	**62**
Early Better Outcomes																		
Collaboration/Partnerships/Teams	**4**						1					1			1		1	
Sensitive Staff/Can Relate	**4**								1	1			1				1	
Community/Client Involvement in MH Process	**3**					1					2							
Service Engagement/Benefits	**2**					**1**											**1**	
• General	1					1												
• Families/Parents	1																1	
Service Integration/Continuity of Care	**2**						1				1							
Systems Support/Assistance/Navigators	**2**									1				1				
Accountability	**1**											1						
Case Management	**1**								1									
Referral Network	**1**													1				
Service/Treatment Effectiveness/Acceptance/Utilization	**1**						1											
Unaddressed/Exacerbated Mental Health Conditions/Higher Levels of Care/Poor Social Conditions	**1**					1												
Other	**6**				2			1	1				1					1

*The focus group did not have an opportunity to respond to this question.

APPENDIX B: Data Tables by Focus Group

Table 11A: Recommendations for Informing Communities about PEI

		Number of Mentions by Focus Group																
Recommendations	**CW**	**1**	**3**	**6**	**7**	**8**	**12**	**13**	**14**	**17**	**23**	**28**	**33**	**34**	**41**	**50**	**56**	**62**
Outreach/Education/Awareness	**125**	**2**	**7**	**5**	**3**	**19**	**7**	**10**	**6**	**1**	**7**	**6**	**6**	**16**	**6**	**5**	**6**	**12**
• Specific Mediums	56	1	3	1	1	3	3	8	3	1	5	2	2	4	3	4	4	8
• Specific Locations	39		2	2	2	15		2	2				1	8	1	1		3
• General	11						1		1		1	3	2	2			1	
• Linguistic/Cultural Appropriate Messaging	7		1				1				1			2	1			
• Messaging	5			1			1					1					1	1
• Target Populations	3	1		1									1					
• Families/Parents	3		1			1									1			
• Available Services	1						1											
Specific Strategies/Approaches	**4**			1	1							1				1		
Systems Support/Assistance/Navigators	**3**									2			1					
Collaboration/Partnerships/Teams	**2**											1						1
Staff/Provider Education/Training/Recruiting	**2**	1													1			
Access Issues-Geographic	**1**									1								
Accountability	**1**						1											
Community/Client Involvement in MH Process	**1**								1									
Funding and Resources	**1**		1															
Location-based Services	**1**				1													
Service Integration/Continuity of Care	**1**			1														
Other	**6**		1			4							1					